Introduction.

In the summer of 2005, the NASDDDS staff launched a study of developmental disabilities case management policies and practices. The study was aimed in part at updating information gathered during an earlier Association-sponsored study of Medicaid case management financing policies and how they were being applied by the states. But, the NASDDDS staff also hoped to gain a better understanding of the changes that are occurring in case management policies and practices across the United States by gathering a wider range of survey data and also conducting a series of in-depth interviews with knowledgeable officials in a small sample of states.

The initial study task involved updating the Association’s 1998 report on optional approaches to financing case management services through the federal-state Medicaid program. The second edition of this report, entitled *Medicaid and Case Management for People with Developmental Disabilities: Options, Practices and Issues*, was released by the Association in May 2006.¹ The report describes federal policies governing Medicaid payments for targeted case management services, administrative case management activities, and case management furnished as part of a federally approved Medicaid home and community-based waiver program, including the latest iterations of federal policies affecting each of these funding options. It also summarizes the ways in which states are utilizing these optional financing strategies to obtain federal financial participation in the cost of case management services.

Next, in order to gain a general sense of the status of DD case management services nationwide, the NASDDDS staff conducted a survey of member state agencies during late 2005 and early 2006. The purpose of the present report is to summarize the results of this nationwide survey. The survey results also will be used to inform the process of selecting states that will be asked to participate in the concluding, in-depth interview phase of the study.

Survey Methodology.

In September 2005 all 50 states and the District of Columbia were informed of the Association’s intention to collect information on case management policies and practices as they impact on people with developmental disabilities (DD). The purpose of this communication was to encourage state DD agency leaders to participate in the upcoming survey. The actual survey instrument was transmitted to member state agencies in October 2005. With the assistance of the staff of ArcLink, the survey questionnaire was posted on the Internet in order to simplify the process of completing the instrument and tabulating the results.²

The survey instrument consisted of 47 multiple choice and short-answer questions, with space provided for

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² Special thanks to Elbert Johns and other involved members of The ArcLink staff for their assistance in designing the Web-based application and posting the survey instrument on the Internet.
clarifying narrative explanations if needed. It was designed to gather information regarding the methods states use to finance case management services, the types of populations served, administrative practices in delivering case management services, including the unit of service and reimbursement rates used by the state, caseload ratios and information on the involvement of case managers in quality management activities and self-directed services. States were asked to base their responses on the most current data available. With some exceptions, states based their responses on FY 2005 data.

Beginning about six weeks after the survey questionnaire was posted on the Internet, the NASDDDS staff followed-up by email and telephone with non-responding states. Completed survey questionnaires eventually were received from 47 member state agencies, representing 92 percent of the Association’s membership.

Summary of Survey Findings.

Federal Financing of Case Management Services. As detailed in the second edition of the Association’s report on federal case management financing options, states use a variety of methods to recover federal payments for case management activities. Principally, these methods include: (a) treating case management as a reimbursable service under one or more Medicaid home and community-based waiver (HCBS) programs; (b) covering targeted case management services as a discrete services for a defined group (or groups) of persons with developmental disabilities under the state Medicaid plan; and/or (c) incorporating allowable elements of case management activities as administrative costs under the state’s administrative cost recovery plan. States may choose to employ any of these methods, singularly or in combination with one another, to recover case management costs as long as they do so in compliance with all applicable federal policies and do not “double bill” for the same service or activity.

As was the case in 1998, the largest number of states reported that they finance case management services for defined groups of persons with developmental disabilities through the targeted case management (TCM) state plan option. The majority of the responding states, 32 out of 47, or 68 percent, indicated that they use the TCM state plan option to recover DD case management costs. Although the survey did not ask states to provide detailed data on the total, unduplicated number of recipients of each type of Medicaid financing option, the survey did instruct states to indicate, within specified ranges, the number of persons served using each type of Medicaid case management financing option. Not surprisingly, the TCM option accounted for the largest numbers of individuals receiving Medicaid-reimbursed case management services. Of the 16 largest state DD systems — those serving over 15,000 individuals — nine use the TCM option to finance the bulk of their case management services. And the two states with the largest number of service recipients (i.e., state DD service systems serving more than 50,000 individuals) both use the TCM option to finance case management services.

Although TCM remains the most commonly used method of recovering federal Medicaid financial participation for case management services, 23 states (almost 49%) offer case management as a covered service under one or more home and community-based waiver programs for persons with developmental disabilities. Ten states provide case management services to 5,000 or fewer HCBS waiver participants, with only two states serving more than 15,000 individuals through this financing option. Ten of the 23 states that bill for case management services under one or more HCBS waiver programs also use the TCM state plan option to recover federal payments.
for DD case management services. In these states, typically the TCM state plan option is used to recover federal CM reimbursements on behalf of individuals who are not enrolled in the state’s DD HCBS waiver program(s). In 1998, more states (18) billed for case management services through both the TCM state plan option as well as under one or more HCBS waiver program. It appears that during the intervening years, additional states have eliminated case management as a service coverage under their HCBS waiver programs in favor of claiming reimbursement under the TCM state plan option.

Several states now claim reimbursement for case management services on behalf of individuals with developmental disabilities who are participating in a Section 1115 research and demonstration waiver program. The Association’s 1998 membership survey did not request information on the use of the Section 1115 waiver authority to cover case management services, as at that time only Arizona, which operates its entire DD service system under this type of waiver, used the 1115 authority to claim Medicaid reimbursement for case management services. In responding to the 2005 survey, five states (10.6%) reported using an 1115 waiver as a source of Medicaid financing for case management services and a sixth state indicated that it was awaiting approval of its 1115 waiver at the time the survey was conducted. [N.B., The latter state’s waiver request has since been approved.]

The administrative claiming option was used by only six states (12.8% of respondents). This is the same number of states that reported they were using the administrative claiming option during the Association’s 1998 survey. It is worth noting, however, that only two states use the administrative claiming option exclusively, as compared to four states in 1998. Four of the states use the administrative claiming option in tandem with HCBS or TCM billings for case management service.

Clearly, TCM and the HCBS waiver reimbursements are the preferred funding options, in all likelihood due to the ability of states to broadly craft definitions of case management services, thus permitting them to recover the maximum level of federal financial participation. In contrast, only certain types of activities can be treated as reimbursable administrative costs under CMS policies. And, with CMS’ recent emphasis on assuring freedom of choice when case management is offered as a waiver service, more states have shifted from claiming reimbursement for case management as a waiver service to claiming reimbursement as a TCM state plan service when such services are furnished through an area-wide single-point-of-entry agency (such as county or regional agency).

**State and Local Funding Sources.** Thirty-five (35) states reported that they use state only funds to cover the cost of case management services to selected service recipients. Eight states indicated that they use local dollars (such as county funds) to pay for case management services. These states provide state or locally funded case management services mainly to individuals who do not qualify for Medicaid or are Medicaid-eligible but do not participate in any of the state’s HCBS waiver programs. Twelve states indicated that they serve less than 1,000 individuals with state-only dollars, seven other states reported that they serve between 1,000-5,000 individuals, and seven states said they served 5,000-10,000 individuals with state only case management funding.

HCBS waiver enrollment grew from 221,909 in 1997 to 424,855 in 2004, or by more than 100 percent.³ Although states continue to use state and local funds to serve certain groups, the total number of recipients of state/locally funded case management services has remained flat over the past eight years.

The Association’s previous report on case management services indicated that about 73,000 individuals nationwide were receiving state-funded case management services. A rough estimate of data reported in the 2005 recent survey indicates that approximately the same number of individuals (est. 76,000) were

receiving state-funded case management services despite the substantial growth in the overall numbers of individuals enrolled in Medicaid HCB waiver services. This trend is consistent with a pattern observed in other types of services. In other words, states are becoming more and more reliant on federal Medicaid reimbursements and, conversely, unmatched state and local dollars are diminishing as a source of financing.

**Units of Service.** The most commonly reported service billing unit is a month for both TCM and HCBS waiver case management services. The second most commonly used billing unit is the 15 minute increment. It appears that despite initial fears regarding a HIPAA requirement that services be reported in 5-minute increments, only two states currently report case management service usage in five-minute increments for Medicaid billing purposes.

States do not use a unit of service rate in claiming administrative case management expenses. Typically they claim reimbursement based on a cost allocation plan grounded in time studies that verify the claiming methodology. Most states reported that general funds (state or local funding) for case management services were not paid for on a unit of service basis; instead entities providing case management and other services usually are compensated a fixed sum (grant) basis.

**Payments for Case Management Services.** Although the survey results indicate that many states base Medicaid payment rates on a monthly unit of service, payment rates for a “comparable” unit of service vary widely. Payments in states with a monthly unit of service, for example, range from a low of $50 per month to a high of $501 per month. No doubt, there are many factors contributing to the wide variation in payment levels, such as the scope of CM duties, the qualifications of the personnel, the type of personnel delivering the service (e.g., state personnel vs. private agency employees; unionized vs. non-unionized employees), and the costs of living differential in various parts of the country. All of these factors and more contribute to variations in case management payment rates.

As an example, one state indicated that its case management payment rate varies from $154.60 per month to $276.08 per month depending on the legal status of the individual and the type of living arrangement. Another state reported that for state personnel the case management payment rate is over $400 per month, with other types of CM provider agencies reimbursed at $292 per month.

As can be seen from Chart 2, the average monthly payment rate was $191.42, with the median monthly rate falling in the $100-250/month range. Chart 2 also shows the number of reported rates falling within established monthly payment ranges.

Five states reported rates that are specific to the type of population and/or the type of provider furnishing the service. Six additional states indicated that TCM rates vary based on other factors, such as geographic location or the use of an allowable cost approach rather than a set statewide rate.

The flexibility of the TCM coverage option, which allows states to target multiple sub-populations within a broad eligibility group such as individuals with developmental disabilities, the variability in rate-setting methods, and the operation of multiple waivers within the same state

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4 N.B. States indicated both multiple rates tied to different populations and funding stream as well as a single rate regardless of funding stream or population type, thus the numbers of rates are not aligned with the number of states reporting. This chart simply indicates the number of reported rates falling into predetermined ranges.
often results in multiple payment rates for case management services.

**Providers of Case Management Services.** Many states reported that they use a mix of provider types to deliver case management services, depending on the population being served; but governmental entities, either state or county, are the most common type of provider of case management services. Currently 23 states indicated that they use state personnel employed by the developmental disabilities authority (SDDA) to provide case management services. Fourteen of these states also use other types of case management providers, such as private-for and nonprofit agencies, other sub-state agency personnel, such as county or regional office employees or stand-alone CM agencies/practitioners.

Eleven states use county personnel to provide case management services, with only two of these states indicating that counties are the sole provider of case management services. States using county case managers, like those using state personnel, often also contracted with other types of organizations to delivery case management services for selected segments of the DD population receiving publicly funded services.

Of the 47 survey respondents, 15 states use independent, stand-alone entities to provide case management services. Of these 15 states, only one relies on this option as its sole source of case management services. Again, most states use a mix of CM providers, tailored to different populations and different needs.

State DD agencies rarely use personnel from other public authorities, such as the single state Medicaid agency or the state health department, to furnish case management services. Only two states indicated that personnel from other state agencies provide case management services to individuals with developmental disabilities.

**Caseload Ratios.** The Association’s staff receives a steady stream of inquires from member state agency officials concerning “standard” and “best” practices in establishing minimum and maximum CM caseload ratios. The subject is fraught with complexity since the scope of a case manager’s responsibility, the intensity of needs among the individuals and families receiving services, and the reality of fiscal limitations can confound any straight-forward comparison of caseload ratios.

The individual-to-case manager ratios reported as part of the current survey provide, at best, a broad-brush, national “benchmark” of caseload sizes. Some states assign case managers differential caseloads depending on the source of funding and/or the types of individuals being served. For example, one state reported an average caseload ratio of 1:50 (that is one case manager for every fifty individuals) for Medicaid-funded targeted case management services provided to individuals served in its HCBS waiver program, but indicated that caseloads ratios for children can be as high a 1:300. Officials in this state indicated that the ratio is high for children due to a state policy that all identified children must be assigned a DD case manager, even if all of the child’s services are currently being furnished through other state agencies (e.g., the local public schools; child welfare agencies; health dept. programs; etc). Although the child and/or family may or may not have a need for active case management services, the family does have an assigned individual to contact should the need arise.

Another state reported that, although the caseload ratio for individuals enrolled in its HCBS waiver program is 1:72, the ratio is higher (1:99) for individuals who received state-only funded services or Medicaid state plan services only. Moreover, for individuals receiving no paid services, the caseload ratio can rise as high as 1:500. With the permission of these two states, we are reporting only the caseloads figures applicable to participants in the state’s HCBS waiver program and/or those adults enrolled in specialized DD services. By eliminating the “outlier” caseload data and reporting only data on persons enrolled in adult service programs (including programs funded through the state HCBS waiver program), the NASDDDS staff believes that the caseload data from these states most closely parallels the data reported by other states. Although only two states reported such wide disparities in caseload ratios,
the data emerging from NASDDDS’ latest survey should be viewed as an indication of the general range of average caseload sizes from state to state (across populations and funding streams), rather than precise caseload ratios that are applied uniformly across all populations served in the reporting states.

As can be seen from the data presented in Chart 3, the most commonly reported caseload ratios fell in the range of one case manager to 30 to 39 individuals. Fifteen states indicted estimated average CM caseloads in this range. But seventeen states reported higher average caseloads than 1:30-39, with two states indicating an average caseload of over 100 individuals to each case manager.

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<th>Chart 3: Estimated Caseload Ratios</th>
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N=50 N=47

Member state agencies were asked whether they have written policies governing caseload size that relate either to the type of population served and/or the type of funding used to finance case management services. Twelve states indicated that they had policies governing caseload size related to the characteristics of the populations being served. Generally, these policies single out children, medically fragile individuals, forensic populations, and individuals with co-occurring conditions (behavioral disorders, or mental health and substance abuse needs) for enhanced case management support, usually in the form of lower individual-to-case manager ratios.

Conflict of Interest. In November 2005, CMS published a new waiver application template with accompanying instructions. The instructions clarify many previously ambivalent policies governing the organization, management and financing of HCBS waiver services. In instructions on Participant Centered Planning and Service Delivery (found in Appendix D-2 of the application template), CMS asks states to indicate the safeguards that are in place for individuals “… when entities that furnish direct waiver services have responsibility for service plan monitoring to avoid problems (e.g., self-monitoring) that may arise in this circumstance.” Since frequently case managers are responsible for service plan development and oversight of direct services, NASDDDS’ survey questionnaire asked states if they have any conflict of interest policies regarding the co-provision of case management and direct services by the same provider agency or organization.

Twenty-seven states reported that they do not permit providers of case management services to offer other direct services to individuals they case manage, while 20 states indicated that service providers may offer both case management and other direct services. The 20 states that allow case management agencies to provide other direct services all have policies in place to ensure the freedom of choice of service participants. Six states stipulate that the case management unit within the provider agency must operate at arms length from other agency operating units — i.e. there must be an organizational “firewall” between the case management unit and other direct service operating units within the agency. Nineteen of these twenty states reported that service recipients must be offered and permitted to choose other service provider agencies. Fourteen states indicated that the service recipient has full authority to request case management from another agency and eight states said that when a provider offers both case management and other direct services, the individual’s service plan has to be approved by the state agency. Given the new CMS requirements governing freedom of choice safeguards, it is apparent that states have instituted formal practices and policies

5 Appendix D-2, Instructions, Technical Guide and Review Criteria, Application for a §1915(c) Home and Community-Based Waiver [Version 3.3], p. 167.
that assure choice for individuals and mitigate potential conflicts of interest.

**Case Management and Supports Brokerage.** The results of the survey provide further evidence of the growth in self-directed developmental disabilities services across the nation. Of the 47 responding states, 37 reported that their state DD agency offers supports brokerage in one form or another to individuals and/or families who elect to direct their own services. With the recent inclusion of supports brokerage as a stand-alone service under federally approved HCBS waiver programs, some states have “decoupled” supports brokerage from traditional case management services. Fourteen respondents to NASDDDS’ latest case management survey indicated that to assist in participant direction their state offers supports brokerage as a completely separate, stand-alone service from “traditional” case management. Most of the remaining states providing supports brokerage services indicated that they use the TCM state plan option to finance “traditional” case management services and offer supports brokerage as an HCBS waiver financed services in tandem with traditional case management services. Four of these states also offer supports brokerage as part of case management services or as a component of another service to selected populations.6

Twelve states reported that they offer supports brokerage services as an integral part of traditional case management services, with two of these states also indicating that they offer other forms of supports brokering as well. Seven states said that supports brokerage is a component of another covered service, such as a fiscal intermediary or family support-type service.

Although member state agencies continue to use traditional case managers to provide supports brokerage for individuals and/or families who direct their own services, more states appear to be drawing a distinction between the two types of services and separating supports needed for self-direction from case management services. It will be interesting to see during future Association surveys if this emerging trend continues.

**Case Management and Quality Oversight.** In view of CMS’ new requirement that a state describe its comprehensive quality management strategy in any future HCBS waiver requests and demonstrate its capacity to identify and rectify any deficiencies that occur in the delivery of waiver-financed services (see Appendix H of the new waiver application), several questions were included in the survey concerning the role of case managers in the state’s quality management process. States were asked if they have developed specialized tools or protocols that case managers use in monitoring the appropriateness and quality of services. Of the 47 survey respondents, 29 states indicated that they have formal tools which case managers use to collect quality performance data and/or written protocols for monitoring individual support plan implementation and outcomes.

In addition to systematically monitoring individual outcomes, 31 states reported that they formally assess the performance of case managers using tools such as the National Core Indicators or other outcome/performance measures. Of these 31 states that assess case manager performance, 26 states aggregate this information and use it as part of their overall quality management reviews. The results of the survey suggest that states are responding to heightened CMS scrutiny by developing data-based approaches to assessing individual outcomes and the performance of case managers.

**Information Technology.** Member state agencies also were asked whether case files on recipients of services were computerized. Of the 47 responding states, 28 indicated that electronic case records were being used. This feedback suggests that states are beginning to use information technology to assist case managers in performing their job functions more efficiently; but,
it’s also suggests a large number of states remain significantly behind the IT curve.

Conclusions.

The results of NASDDDS’ latest membership survey demonstrate that case management services continue to play a keystone role in the operation of state/local developmental disabilities service systems across the United States. At the same time, the responsibilities of case managers are changing in some states as access to self-directed supports expands and states make available supports brokerage services to replace or supplement functions traditionally performed by case managers.

By most conventional measures, states are more reliant on federal Medicaid dollars to finance case management services today than they were eight years ago when the Association conducted its last case management survey. The TCM state plan option remains the most prevalent source of federal Medicaid financing for case management services, followed by HCBS waiver programs.

As a result of the states’ growing reliance on federal financing, decisions regarding the deployment of case managers are increasingly influenced by the Medicaid policies of CMS. This phenomenon is evident in the ways in which case managers are used to monitor the quality and appropriateness of home and community-based services in the face of new, more explicit federal expectations regard state quality oversight and improvement activities. It also is evident in state rate-setting and payment policies, the states’ responses the CMS’ conflict of interest policies, as well as its policies governing supports to individuals and families who choose to self-direct their services.

Largely due to the rapid growth in home and community-based services for individuals with developmental disabilities over the past ten years, some states have struggled to maintain a sufficient number of qualified case managers to adequately address the needs of service recipients. The wide variability in caseload ratios reported in this study documents the nature of the problem. Some states have attempted to address this problem by assigning differential caseload ratios and functions to case managers serving distinct portions of the service population, based largely on the intensity or types of service needs and source of funding.

Next Steps.

During the concluding phase of the study, the NASDDDS staff will identify six to eight states that are willing to participate in a series of in-depth interviews aimed at learning more about case management policies, practices, trends and challenges in selected jurisdictions. In choosing the target states, the NASDDDS staff will seek to include large, mid-sized and small states located in various regions of the country, as well as states in which case management services are furnished through various types of entities (e.g., by state employees; by county employees; by employees of nonprofit, single-point-of-entry agencies; and by free standing CM agencies/individual practitioners).

An interview guide will be prepared to ensure that similar topics are covered in discussions with key informants in each of the targeted states. The results of each state interview will be summarized and officials in the participating state with be asked to verify the accuracy of the summary. Finally, the commonalities and differences within the target states will be analyzed in a final project report. The NASDDDS staff’s aim is to complete this concluding phase of its case management study by the late fall of 2007.