Texas Health and Human Services Commission

Case Management Optimization

ANALYSIS OF CURRENT CASE MANAGEMENT SYSTEM

NAVIGANT
CONSULTING

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EXECUTIVE SUMMARY

In 2005, the Texas Legislature enacted Senate Bill 1188, which directs the Health and Human Services Commission (HHSC) to assess, review and undertake optimization of case management programs and services across the Health and Human Services (HHS) enterprise.

The HHSC contracted with Navigant Consulting, Inc. for assistance in the optimization of the state's case management services. This report responds to Section 2.4.1.1 of the HHSC Request for Proposals (RFP), which indicates that the contractor will review and analyze current HHS enterprise case management services.

Approach and Information Sources

As a part of this project, Navigant Consulting conducted a review of the various programs delivered by the HHS enterprise that provide some form of case management. This included a review of the following sources of information:

- *Interviews with program managers or staff from each department* – We conducted interviews with program representatives from the Department of Aging and Disability Services (DADS), the Department of state Health Services (DSHS), the Department of Assistive and Rehabilitative Services (DARS) and the Department of Family and Protective Services (DFPS).

- *Program documentation provided by the HHS departments in response to Navigant Consulting's data request* – We reviewed applicable rules and regulations, Medicaid State Plan amendments, program manuals and training materials related to the case management services provided through each of the departments.

- *Focus groups* – As part of the data collection process, we facilitated a series of focus groups with consumers and case managers throughout the state.

- *Telephone interviews with consumer advocates* – We contacted and interviewed representatives of consumer advocacy organizations about their experiences with case management services provided through the HHS enterprise.

- *Analysis of available expenditure and utilization data* – We conducted analyses of expenditure and utilization data from the four departments included in this report to assess utilization, expenditures and the cost-effectiveness of case management services. Due to the differing delivery and reimbursement structures of each program within these departments, the availability and format of expenditure and utilization data was not uniform across the different programs, complicating a uniform and consistent analysis.

- *Telephone and online consumer survey* – We conducted a consumer telephone survey and provided all consumers the opportunity to take the same survey online. We also made a toll-free phone number available for individuals who are blind or visually impaired and preferred to conduct the survey over the phone. In total, we received 1,202 responses: 1,116 from phone interviews and 86 from online surveys.

- *Online and mail-in case manager survey* – We developed an online case manager survey that was also available in paper format for individuals to respond via U.S. mail. We received a total of 247 case manager surveys (online and mail-in surveys) after removing duplicates.

Findings and Observations

Our independent review confirms the issues as reported in the RFP. There are a number of different approaches in place for the delivery, reimbursement, billing, staffing and funding of case management. We also noted, however, a number of similarities regarding these programs. We describe below our main findings and observations.

- *Definitions of Case Management* – Many of the case management programs we reviewed define case management services differently. Programs may also refer to case management services as case management, care coordination, service coordination or care management. A review of the various HHS programs offering case management, or case management-type services, indicates that case management is usually defined to include some or all of the following services:

  - Ensuring Eligibility
  - Assessing Needs
  - Working with Family (if appropriate)
  - Developing a Plan of Care or Individual Service Plan
  - Authorizing Services
  - Coordinating Access to Services
  - Locating Available Services
  - Coordination of Services
  - Monitoring of Services
  - Crisis Intervention
  - Reassessing Consumer Needs

  Some services are unique to one program. For example, case management, provided as a part of guardianship services in the DADS Guardianship Program, is conducted within the general duties and responsibilities as

outlined in the specific Order of the Court.[1] These responsibilities may include managing the wards' estates if appointed as guardian of the estate and making medical decisions about major events such as surgery and life-threatening illness, if appointed as guardian of the person.

In addition, some programs do not offer a distinctive category of service titled "case management," but they do contain some "case management" type functions. For instance, intermediate care facilities for the mentally retarded (ICFs/MR) and nursing facilities do not have case managers on staff; instead, they have qualified mental retardation professionals (QMRPs) or social workers on staff (or contracted) who assist residents in maintaining or improving their ability to manage their everyday physical, mental and psychosocial needs.

The duration and intensity of case management also varies among programs. Some programs such as the Deaf Blind with Multiple Disabilities (DBMD) program offer more intense and ongoing services, based on the needs of their clients; other programs such as the Mental Retardation Local Authority (MRA) program, may provide case management services mainly during the enrollment or eligibility process, only during transition to a different level of care or only during a defined time period.

- *Reimbursement, Funding and Utilization* – The lack of uniform data creates difficulty in comparing utilization, consumers of case management services and expenditures across programs. Examples follow:

  - Case management services can be paid as a separate service, as part of a bundled, all-in-one program rate or with Medicaid administrative funds.

  - Based on the reimbursement methodology, funding stream and program reporting needs, programs collect different types of data related to case management services.

  - There is no common reimbursement methodology for case management services, even within the same program. The state pays for case management services using a variety of methodologies. Within the same program, there may be several funding streams that each use a

[1] The Guardianship Program serves individuals age 18 and older who have been adjudicated incapacitated by a court of law and are disabled and/or aged. Services are not voluntary; clients are brought in through court order. The court order determines what duties and responsibilities the guardian will perform.

separate reimbursement methodology. In the Early Childhood Intervention (ECI) program, for example, contractors providing Medicaid Targeted Case Management submit claims that are paid by Medicaid; costs for non-Medicaid clients are not separately identified because services are paid according to a contracted amount.

- Average payments per consumer vary widely.

- There is little case management utilization data available. Many programs are reimbursed a monthly fee for case management services and do not track data regarding the number of encounters provided or the type of services provided in each case management session. For example, Community Living Assistance and Support Services (CLASS) providers record the number of months of case management services provided as opposed to the number of encounters, hours or minutes of service provided. As such, it is not possible to calculate the average number of encounters a consumer may have received. On the other hand, in the Adult Mental Health Services Program, providers bill units in 15 minute increments, allowing for more meaningful analyses of utilization.

- *Resource Availability* – There are variations in caseloads and qualifications for case managers or those who perform case management-type functions across the departments.

  - Caseloads vary across programs from seven in the Adult Protective Services (APS) Facility Investigations program to several hundred in the Community Based Alternatives (CBA) and Community Care for the Aged and Disabled (CCAD) programs. Additionally, some case managers reported that their large caseloads have made it more difficult for them to form deep relationships with their clients and serve them more directly.

  - For many of the programs reviewed, state staff perform case management. Generally, state staff who provide case management are employed by the department that is responsible for the program.

  - The qualification requirements for case managers also vary considerably across programs. Program requirements for case manager qualifications range from a high school education to graduate-level education with experience; some programs require medical or other licensed professionals such as RNs or licensed social workers.

- *Coordination and Knowledge Sharing Between Programs* – Based on the design and function of the case management program, the level of coordination between programs, departments and other organizations varies widely. For example, approximately two-thirds of case manager survey participants indicated that insufficient coordination across agencies is a major or moderate problem within the case management system in Texas.[2] Additionally, state staff reported during targeted interviews that effective data sharing among HHS departments and programs is an issue. A number of departments and programs reported in targeted interviews and focus groups that case managers do not have the information they need about other services that clients are receiving. Others reported that they rely on self-reported data from clients. Some case managers expressed concern that clients would encounter a "wrong door" and subsequently be turned away for services. Some advocates also noted that case managers may not know about other services their clients are receiving or may not know about available services outside of their program (e.g., community or non-profit organizations or other state or federal programs).

- *Geographic Issues* – Although there appears to be issues regarding the delivery of case management services specific to rural areas of the state related to supply of case management professionals, in general, geographic issues appear to primarily impact the services that case managers authorize for their clients. For example, feedback from consumer and case management staff focus groups identified difficulties obtaining necessary services for consumers in rural areas. Case managers also indicated that as a result of a scarcity of services in those areas, case managers often provide more direct care services and establish a close working relationship with consumers.

- *Administrative Issues* – One of the areas of focus of this study is the extent to which consumers have multiple case managers and the effect that this has on consumers. In both focus groups and surveys, consumers and case managers reported similar attitudes toward having multiple case managers, i.e., having more than one case manager is not necessarily viewed negatively by consumers and case managers. Consumers and case managers are both concerned, however, about duplication in the areas of intake and assessment.

Additional information regarding our analysis of the current case management system, including descriptions of each of the HHS programs providing case management services are provided in the detailed report.

[2] Of a total of approximately 245 participants.

I. INTRODUCTION

In 2005, the Texas Legislature enacted Senate Bill 1188, which directs the Health and Human Services Commission (HHSC) to assess, review and undertake optimization of case management programs and services across the Health and Human Services (HHS) enterprise. Optimization efforts include:

- Making case management more efficient and cost-effective
- Ensuring quality consumer services
- Optimizing Federal and state funding sources
- Enhancing or replacing case management programs not meeting cost or quality targets with proven programs or enhancements
- Assessing the feasibility of a Medicaid waiver combining case management, care coordination, utilization management and other quality and cost control measures and if feasible, developing the waiver

The HHSC contracted with Navigant Consulting, Inc. for assistance in the optimization of the state's case management services. This report responds to Section 2.4.1.1 of the HHSC Request for Proposals (RFP), which indicates that the contractor will review and analyze current HHS enterprise case management services.

In preparing this report, we conducted interviews with state staff and program managers and advocates, conducted focus groups and surveys of consumers and case management staff. We reviewed program documents, including program manuals, Medicaid State Plan amendments and waiver documents as well as previous HHSC reports. Additionally, we reviewed case management-specific expenditure and utilization data, when available.

In this report we provide a summary of each HHS program providing case management services and our findings related to key features of these programs. The report also includes a summary of the major themes that emerged during focus groups with case managers and consumers. We also include results and analysis of the focus groups in the Stakeholder Involvement Report.

Background

The HHSC serves as an umbrella organization for all health and human services programs in Texas. In 2003, the Texas Legislature mandated a restructuring of the state's health and human services with the goal of creating an integrated, effective and accessible system that was focused on clients and responsive to local needs. As a result, throughout 2004, HHSC consolidated 12 agencies into five.

The HHSC coordinates administrative functions across the system, provides Medicaid eligibility determination across programs and administers Medicaid and the Children's Health Insurance Program. The following four departments operate under the oversight of the HHSC:

- Department of Aging and Disability Services (DADS)
- Department of State Health Services (DSHS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of Family and Protective Services (DFPS)

Each department is responsible for the operation of various health and human services programs. Many of these programs provide some form of case management or case management-type service. The scope of this report does not include case management provided as part of HHSC's managed care or primary care case management programs. Consumers in the following programs may receive some form of case management or case-management-type services. The following programs were included in Navigant Consulting's study of case management services provided across the HHS enterprise:

Department of Aging and Disability Services (DADS) Programs and Entities

- Aging and Disability Resource Center (ADRC) pilot programs
- Area Agencies on Aging (AAAs) Care Coordination and Care Management programs
- Community Based Alternatives (CBA) Medicaid waiver program
- Community Care for the Aged and Disabled (CCAD)
- Community Living Assistance and Support Services (CLASS) waiver program
- Consolidated Waiver Program (CWP)
- Deaf Blind with Multiple Disabilities (DBMD) waiver program
- Guardianship Program
- Home and Community-based Services (HCS) waiver program
- Intermediate Care Facility for the Mental Retarded (ICF/MR) Services, community-based and State Schools
- Medically Dependent Children Program (MDCP), a waiver program

- Mental Retardation Local Authority (MRA) case management services
- Nursing facility services
- Relocation Assistance for Individuals Transitioning from Nursing Facilities to Community Settings
- Texas Home Living (TxHmL) waiver program

Department of Assistive and Rehabilitative Services (DARS) Programs

Division for Blind Services

- Blind Children's Vocational Discovery and Development Program
- Vocational Rehabilitation

Division for Early Childhood Intervention

- Early Childhood Intervention (ECI)

Division for Rehabilitation Services

- Vocational Rehabilitation

Department of Family and Protective Services (DFPS)

- Adult Protective Services (APS)
- Child Protective Services (CPS)

Department of State Health Services (DSHS)

- Case Management Services for Children and Pregnant Women (CPW)
- Children with Special Health Care Needs (CSHCN) services program
- Adult Mental Health Services
- Children's Mental Health Services

The remainder of this report is divided into the following sections:

- Approach
- Features of HHS Programs Providing Case Management

- Findings and Observations
- Conclusion
- Appendices

II. ANALYSIS OF CURRENT CASE MANAGEMENT SYSTEM

A. Approach and Information Sources

As a part of this project, Navigant Consulting conducted a review of the various programs delivered by the HHS enterprise that provide some form of case management. This included a review of the following sources of information:

- Interviews with program managers or staff from each department
- Program documentation provided by the HHS departments in response to Navigant Consulting's data request
- Focus groups
- Telephone interviews with consumer advocates
- Analysis of available expenditure and utilization data
- Telephone and online consumers survey
- Online and mail-in case manager survey

Interviews with Program Managers and Staff

In February and March 2007, Navigant Consulting conducted interviews with representatives from the programs that provide case management services. The interviews followed a semi-structured format and included questions related to case management definitions, services provided, case manager qualifications, promising projects and best practices and problems and opportunities.

Navigant Consulting conducted in-person and telephone interviews with representatives from the following programs:

- DADS – AAAs, Guardianship Program, CCAD programs, HCS Waiver, ICF/MR Services, nursing facilities, Relocation Assistance for Individuals Transitioning from Nursing Facilities to Community Settings, ADRC pilot programs, and targeted case management for MRAs
- DARS – ECI; Division for Blind Services, Blind Children's Vocational Discovery and Development Program, Vocational Rehabilitation Program; Division for Rehabilitation Services, Vocational Rehabilitation Program
- DFPS – CPS and APS

- DSHS – CPW, CSHCN Services Program, Adult Mental Health and Children's Mental Health services.

- HHSC Office of Program Coordination for Children and Youth – Texas Integrated Funding Initiative (TIFI) and Community Resource Coordination Group (CRCG) programs

Review of Program Documentation

To conduct our assessment of the current case management delivery system, we reviewed the following materials:

- Rules and Regulations – We reviewed information on applicable rules and regulations provided by the state and on the state's Administrative Code website. The Texas Administrative Code provided information on service definitions, provider qualifications and reimbursement methodology for each program's case management function.

- Medicaid State Plan Amendments – We reviewed the Medicaid State Plan Amendments relating to the Blind Children's Vocational Discovery and Development Program. We also reviewed the State Plan Amendment relating to ECI case management services.

- Program Manuals – We reviewed sections of various state program manuals and handbooks, for example, those used by DADS for case management services. These materials were provided by the state in hard copy and online and detailed the qualifications necessary to be a case management provider and the types of services that case management encompasses.

- Training Materials — We reviewed training materials provided by the state. These included materials for training and orientation for new case managers; training for new social workers; training manuals and presentations for case management services for CPW case managers and administrative staff. We reviewed these materials for information relevant to various aspects of case management, including provider qualifications.

Focus Groups

As part of the data collection to assess the status of case management practices across diverse consumer groups served by DADS, DSHS, DARS and DFPS, we facilitated a series of consumer and case manager focus groups in Texas during the weeks of April 9th and April 16th, 2007. This section of the report describes our approach to organizing and facilitating the focus groups. The Findings section of this report provides a summary of the major themes that emerged during

focus groups with case managers and consumers. We also include information regarding process and results from the focus groups in the Stakeholder Involvement Report.

Our strategy for coordinating these focus groups and identifying participants focused on the need to obtain feedback from consumers and staff from all departments and to reflect the experience of individuals across Texas, (i.e., rural, urban and border areas). We held focus groups in Dallas, Austin, Lubbock, McAllen and Tyler.

Case Management Staff Focus Groups

We held 11 case management staff focus groups over a period of two weeks: a total of seven case management staff focus groups in McAllen, Tyler and Dallas during the week of April 9th, 2007 and four case management staff focus groups in Lubbock and Austin during the week of April 16th, 2007.

We submitted a request to each department asking for names of people to attend these focus groups. These representatives were individuals with approximately five years of experience providing case management and experience with more then one program within the department. We also worked with the different departments to invite private providers to participate in the focus groups.

The case managers that participated in the focus groups represented a wide range of front-line case managers, supervisors and administrators and many have had extensive experience in the field, including professional experience in more than one service system. Participants at the focus groups for case managers were actively engaged in the dialogue and offered varying insights into the status of case management services across DSHS, DADS, DARS, and DFPS. [3]

Consumer Focus Groups

We held 11 consumer focus groups over a period of two weeks: seven consumer focus groups in McAllen, Tyler and Dallas the week of April 9th, 2007 and four consumer focus groups in Lubbock and Austin the week of April 16th, 2006.

We identified consumers who received services from a mix of programs within each department. While we had proposed identifying consumers using lists of consumers from each program, due to confidentiality and safety concerns for some consumer groups this was not possible for all programs – in particular for DFPS consumers and consumers receiving mental health services. To identify focus group participants, we:

[3] In DARS vocational rehabilitation (VR) programs, case management services are provided by the VR counselors.

- Used lists when available
- Requested that programs provide names of consumers
- Sent letters to providers and advocates requesting names of consumers who they believed might be interested in participating in the focus groups. In some cases, we provided a toll-free number for consumers to call to avoid the need for providers to obtain consent forms.
- Requested that programs encourage their consumers to call a 1-800 number to indicate their interest in the focus groups.

While these approaches enabled us to identify many consumers for the focus groups, consumer participation was somewhat lower than originally anticipated

Participants received a $15 cash incentive to encourage participation and reimbursement for transportation was provided, if requested.

Telephone Interviews with Consumer Advocates

We contacted and interviewed representatives of consumer advocacy organizations about their experiences with case management services in the Texas HHS programs. The advocacy organizations represent various populations, including nursing home residents, as well as individuals with disabilities, developmental disabilities and mental illness.

Interviews were semi-structured and included topics regarding case management service delivery, consumer experiences with case management and case managers, quality and availability of case management services and other issues identified by the advocates.

We interviewed representatives from four advocacy organizations and contacted 14 other organizations. We emailed each organization a link to this report and comment form online. We will include detailed information regarding process and results from the interviews in the Stakeholder Involvement Report.

Data analysis

We also conducted analyses of expenditure and utilization data from the four departments included in this report to assess utilization, expenditures and the cost-effectiveness of case management services. We relied on the following sources of information to date:

- Case Management Survey provided by the four departments[4]
- Federally required expenditure and utilization reports for waiver programs (CMS-372)
- Claims data, where available
- Encounter data, where available
- Pre-existing program-specific summaries of encounter and expenditure data

Due to the differing delivery and reimbursement structures of each program within these departments, the availability and format of expenditure and utilization data was not uniform across the different programs, complicating a uniform and consistent analysis. For example:

- Reimbursement methodology variations within the same program create different mechanisms for recording case management expenditures and utilization. In the ECI program, for example, contractors providing Medicaid Targeted Case Management submit claims; costs for non-Medicaid clients are reimbursed by the ECI contract.
- Some programs (i.e., CLASS) pay a per month rate, which represents a minimum of one case management encounter. Providers record the number of months of case management services provided as opposed to the number of encounters, hours or minutes of service provided. As such, it is not possible to calculate the average number of encounters a consumer may have received. In the Adult Mental Health Services Program, on the other hand, providers bill units in 15 minute increments, allowing for more meaningful analyses of utilization.
- In some cases, a program's reimbursement methodology did not allow for the calculation of total case management expenditures, i.e., payment for case management services is included in the per diem rate and not identified separately. In the nursing facilities and ICF/MR programs, for example, payment for case management services is included in the per diem rate and is not separately identified. There does not appear to be sufficient case management data for either program to estimate case management-specific expenditures. In the Findings section of this report, we have included a complete discussion of the ICF/MR and nursing facilities data issues.

[4] Texas Medicaid Administrative Support Services Electronic Procurement Library RFP# 529-06-0333. Available online (March 27, 2007): http://www.hhsc.state.tx.us/Contract/529060333/ProcurementLib.html.

Appendix A provides details of the claims and utilization data available for each program.

For each program within the department, we further identified the following information for analysis. We have presented this more detailed information in Appendix B:

- Total annual case management expenditures
- Total annual unduplicated consumers of case management services
- Total annual units of case management services – due to the varying funding and reimbursement approaches of the different programs, the number of units was not always available
- Average annual case management expenditures per consumer
- Average annual units of case management services per consumer

For some programs where data were available, we also provided information on the types of case management provided. The Findings section of this report provides observations based on this data analysis. Appendix C details the data sources on which we relied.

Telephone and Online Consumer Survey

Navigant Consulting conducted a consumer telephone survey and provided all consumers the opportunity to take the same survey online in Spanish or English on a webpage accessible to individuals who are blind or visually impaired. We also made a toll-free phone number available for individuals who are blind or visually impaired and preferred to conduct the survey over the phone. In total, we received 1,202 responses: 1,116 from phone interviews and 86 from online surveys.

Online and Mail-In Case Manager Survey

Navigant Consulting also developed an online case manager survey that was also available in paper format for individuals to respond via U.S. mail. We received a total of 247 case manager surveys (online and mail-in surveys, after removing duplicates).

Note that given the approaches used to identify consumers for the survey and the related challenges, as well as the relatively low response rate from case managers, the survey results referred to this report are not statistically representative of the HHS enterprise's case

management services in total, or by Department. Care must be taken when drawing conclusions from the findings. [5]

The Findings section of this report provides observations based on the analysis of the survey data. We include detailed information regarding process and results from the surveys in the Stakeholder Involvement Report.

B. Features of Health and Human Services Programs Providing Case Management

Appendix D provides a number of tables detailing the results of Navigant Consulting's review of the Texas HHS programs that provide case management services. We provide information by department and then by program as follows:

- Program Description: This provides a brief description of the overall program, including the types of services available and the target population.
- Case Management Service Definition: This section provides the definition of case management as used in that program. Some programs do not specifically have a service called "case management." Sometimes case management is given another name and sometimes services are provided that are similar to those traditionally provided under case management.
- 1915(c) Waiver Service: This section indicates if case management is provided as part of a waiver program.
- Delivery Model: This section explains who provides case management services. Very often case management services are provided through either a contracted agency or by qualified state staff.
- Coordination with other Agencies: This section indicates which departments, programs or other agencies or organizations with which the case managers most frequently coordinate, in terms of referrals of clients and discussions of issues related to case management.

[5] The consumer lists that Navigant Consulting received contained some consumer phone numbers that were invalid (i.e., disconnected or wrong numbers), some individuals who were deceased and some consumers who indicated they had not received services. For some lists, a high proportion of consumers did not have telephone numbers recorded.

- Case Manager Qualifications: This section details the necessary qualifications for an individual to provide case management services. This often includes a specified level of education and/or experience.

- Program Funding Source: This section provides the source of funding for the program. Potential sources of funding include, state general revenue; Medicaid (Federal Medical Assistance Program Matching Funds or Federal Administrative Matching Funds) or some other federal program.

- Program Reimbursement Methodology: This section provides the method which is used to establish the rates paid for the program, specifically case management services.

- Performance Measures: This section describes specific performance measures used to evaluate the effectiveness of case managements services.

- Claims Systems/Databases: This section indicates the availability of program data, specifically case management expenditure, utilization, recipient, performance or other data.

C. Findings and Observations

In this section, we provide a summary of our findings from our review of case management programs and data. We also provide information gathered from focus groups and interviews with stakeholders. First, we describe our findings in the key areas of definitions of case management, funding and reimbursement, resource availability, rural issues, knowledge sharing and coordination between programs, administrative issues and other issues. Next, we provide an overview of stakeholder feedback in those same key areas.

The Appendices present several tables that summarize programs in terms of expenditures and utilization, as referenced earlier in the report. Additionally, the Appendices include summaries of the populations served, service providers and caseload. Appendix B displays the case management-specific claims and utilization data for each program that provides case management services within the four departments. Appendix C displays the data sources for each program. Appendices E through I presents an overview of HHS programs that provide case management services and identify similarities and differences between programs serving a similar population.

<u>Summary of Variations and Similarities in Program Features</u>

Our independent review confirms the issues as reported in the RFP. There are a number of different approaches in place for the delivery, reimbursement, billing, staffing and funding of case management. We also noted, however, a number of similarities regarding these programs.

Definitions of Case Management

Based on our review, our findings across all programs for each category of inquiry indicate:

- Programs may refer to case management services as case management, care coordination, service coordination or care management. Each program may define case management services slightly differently.

  A review of the various HHS programs offering case management, or case management-type services, indicates that case management is usually defined to include some or all of the following services:

  - Ensuring Eligibility
  - Assessing Needs
  - Working with Family (if appropriate)
  - Authorizing Services
  - Developing a Plan of Care or Individual Service Plan
  - Coordinating Access to Services
  - Locating Available Services
  - Coordination of Services
  - Monitoring of Services
  - Crisis Intervention
  - Reassessing Consumer Needs

  Some services are unique to one program. For example, similar activities, provided as a part of guardianship services in the DADS Guardianship program, are conducted within the general duties and responsibilities as outlined in the specific Order of the Court. These may include managing the wards' estates if appointed as guardian of the estate and making medical decisions about major events such as surgery and life-threatening illness, if appointed as guardian of the person.

  In addition, some programs do not offer a distinctive category titled "case management." However, these programs do contain some "case management" type functions. For instance, ICFs/MR and nursing facilities do not have case managers on staff; instead, they have qualified mental retardation professionals (QMRPs) or social workers on staff (or contracted) who assist residents in maintaining or improving their ability to manage their everyday physical, mental and psychosocial needs.

- The duration and intensity of case management varies among programs. Some programs offer more intense and ongoing services, based on the needs of their

clients; other programs may provide case management services mainly during the enrollment or eligibility process, only during transition to a different level of care or during a defined time period.

For example:

- The DBMD program serves a small, high-needs population. Case managers for the DBMD program not only assist clients with enrollment and eligibility, they plan, coordinate (and some times provide) consumer services and advocate on behalf of their clients.

- The CBA program provides initial case management activities that include eligibility and enrollment. In addition, CBA case managers coordinate consumer services and advocate on behalf of their clients. The duration and frequency of these case management activities depend on the needs of the consumer.

- In some cases, MRAs are responsible for case management only during the consumer's enrollment period in a waiver program or during a transition to or from a facility.

- The DFPS APS program only provides case management during the period of investigation and service delivery designed to identify and ameliorate abuse, neglect or exploitation.

- Targeted case management is defined, according to the Deficit Reduction Act, as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services" and excludes "the direct delivery of an underlying medical, educational, social or other service to which an eligible individual has been referred."[6] There are specific activities that are eligible for federal reimbursement such as service needs assessment, development of a care plan, referral, monitoring and follow-up activities.

  Among Texas programs that provide targeted case management, there is little uniformity in reimbursement methodologies and rates for targeted case management services. DSHS Mental Health pays for targeted case management services in 15-minute increments, while other departments pay a monthly or per unit

[6]Section 1915(g)(2)(iii)(I) thru (VIII) of the *Social Security Act*, as added by Section 6052 of the Deficit Reduction Act of 2005 (P.L. 109-171).

rate. Appendix F shows the reimbursement rates for those programs offering targeted case management services.

Reimbursement, Funding and Utilization

Our observations regarding reimbursement, funding and utilization are complicated by the variation in availability and type of data among programs, as shown in Appendix B. The variation in data is a function of program reimbursement methodology, funding streams, service delivery models and definitions of case management as described above and does not indicate a deficiency on the part of any program. It is not appropriate or necessary for all programs to have a claims data system or case management-specific claims data. However, the lack of uniform data creates difficulty in comparing utilization, consumers of case management services and expenditures across programs. For example:

- Case management services can be paid as a separate service, as part of a bundled, all-in-one program rate or with Medicaid administrative funds. As described later in this section, in some cases, case management services are integral to total service delivery. For example, nursing facilities and ICFs/MR provide case management-type functions as part of the resident's plan of care. These programs do not separate costs or separately identify case management services.

- Based on the reimbursement methodology, funding stream and program reporting needs, programs collect different types of data related to case management services. Programs that bill Medicaid directly for case management services will have claims data available for review and analysis. Other programs, including those that claim Medicaid administrative match for case management services do not have claims data.

  The administrative match refers to the Federal financial participation for allocable costs that the Medicaid or other agency incurs in the activities arising from the administration of a state's Medicaid program. A time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by state employees for targeted case management services. A time study serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid. Some common case management activities that fall under administrative claiming include Medicaid eligibility determination, Medicaid intake processing, the prior authorization of Medicaid services and preadmission screening or level of care evaluations. For example:

  - There are Medicaid claims data for programs that bill Medicaid for Targeted Case Management Services. These programs are listed in Appendix E.

  - In programs where state staff provide case management services and claim Medicaid Administrative match, such as the CBA and CCAD programs, there is no claims data and no unit or payment information.

- For the reasons described above, some programs (as shown in Appendix B) cannot provide the total units of case management services provided. As such, for several programs such as the CBA and CCAD, average units per consumer cannot be calculated in a way that allows for comparability of data across programs.

- There is no common reimbursement methodology for case management services, even within the same program. The state pays for case management services using a variety of methodologies. Within the same program, there may be several funding streams that each use a separate reimbursement methodology. In the ECI program, for example, contractors providing Medicaid Targeted Case Management submit claims that are paid by Medicaid; costs for non-Medicaid clients are not separately identified because services are paid according to a contracted amount.

- Average payments per consumer vary widely. For example, within the DADS programs, the average annual payment per consumer varies from $108.63 (Day Activity Health Services) to $2,020.43 (Mental Retardation Local Authority Services).[7] This variation is, in large part, due to the differences in services provided between the different DADS programs.

- There is little case management utilization data available. Many programs are reimbursed a monthly fee for case management services and do not track data regarding the number of encounters provided or the type of services provided in each case management session. For example:

  - CLASS providers record the number of months of case management services provided as opposed to the number of encounters, hours or minutes of service provided. As such, it is not possible to calculate the average number of encounters a consumer may have received.

  - In the Adult Mental Health Services program, on the other hand, providers bill units in 15 minute increments, allowing for more meaningful analyses of utilization.

- Nursing facilities and ICFs/MR do not provide a service called "case management", but do provide case management-like services to residents, which are included in the per diem rate paid to the facility by the state. However, the state does not require

[7] Appendices B.1 through B.4 provide details on the average annual payments per consumer by program

facilities to track or report which case management-type services residents receive. As such, there is insufficient case-management specific data to determine utilization, recipients and expenditures.

- The state pays ICFs/MR a per diem rate that covers all services, including case management-type functions, for residents. ICFs/MR do not receive additional payment outside of the per diem for case management-type functions. It is not possible to separately identify either the costs of the case management services or payment for these services.

  ICFs/MR are required by Federal regulations to provide "active treatment" by an interdisciplinary team. Active treatment includes aggressive, consistent training, treatment and health services.[8] The ICF/MR residents' active treatment plans must be integrated, coordinated and monitored by a QMRP employed by the facility. In addition to providing case management services related to overseeing residents' active treatment plans, the job duties of a QMRP typically include other functions. DADS staff report that QMRPs have additional duties such as providing direct services to residents, hiring, training and supervising direct service staff and performing administrative or financial functions for the facility.

  Although there are Federal regulations regarding active treatment and functions and responsibilities of the QMRP, the regulations do not specify if the person designated as QMRP must perform the duties of a QMRP exclusively.[9] It is up to the facility to determine to what extent the QMRP performs other professional staff duties in addition to QMRP duties.[10] The facility has the flexibility to allocate staff resources in whatever manner it believes is necessary as long as it ensures that the QMRP function is performed effectively for each individual.

  The Texas HHSC cost reports for ICFs/MR include a line item for QMRP costs. However, the job description of a QMRP includes functions other than case management. There is no line item on the cost report specific to costs for case management functions and the state does not collect any data from ICFs/MR regarding the percentage of time QMRPs spend on case management functions. Based on the information available, it is not possible

[8] 42 CFR 483.440(a).
[9] 42 CFR 483.430(a).
[10] Centers for Medicare and Medicaid Services, "State Operations Manual Appendix J." Available online: http://www.cms.hhs.gov/manuals/downloads/som107ap_j_intermcare.pdf.

to determine what percent of QMRP costs are related to case management functions.

- Similarly, the state pays nursing facilities a per diem rate that covers all services, including case management-type functions, for residents. Nursing facilities do not receive additional payment outside of the per diem for case management-type functions. It is not possible to separately identify either the costs of the case management services or payment for these services.

  Case management for nursing facility residents is performed by social workers employed by or contracted with the facility; social workers may also provide direct services to residents in addition to performing case management functions. In addition to facilitating the admissions process and developing the individual plan of care, social workers can provide social and psychosocial care to residents and families (e.g., providing crisis management, helping families cope with loss).[11]

  Although nursing facilities do submit cost data for social workers to the state, there is no line item on the cost report specific to case management costs. The state does not collect any data from nursing facilities regarding the percentage of time social workers spend on case management functions. Based on the information available, it is not possible to determine what percent of social worker costs are related to case management functions.

  Additionally, neither ICFs/MR nor nursing facilities receive 100 percent of costs as payment; they are paid prospective rates that may pay less than 100 percent of reported costs. Thus, we could not calculate the precise payment amount that is made for those services.

Resource Availability

As a result of our review, we noted variation in caseloads and qualifications for case managers or those who perform case management-type functions.

- Caseloads vary across programs from seven in the APS Facility Investigations program to several hundred in the CBA and CCAD programs. Additionally, some case managers have reported that large caseloads made it more difficult to develop close relationships with their clients. Appendices C through G include approximate caseloads. Some programs are not able to determine caseloads or leave caseloads up

[11]National Association of Social Workers, "Clinical Indicators for Social Work and Psychosocial Services in Nursing Homes." Available online: http://www.socialworkers.org/practice/standards/nursing_homes.asp

to the discretion of a contracted case management provider or to state-employed staff.

- For many of the programs reviewed, state staff perform case management. Generally, state staff who provide case management are employed by the department that is responsible for the program.

- The qualifications requirements for case managers also vary considerably across programs. Program requirements for case manager qualifications range from a high school education to graduate-level education with experience; some programs require medical or other licensed professionals such as RNs or licensed social workers. For example:

  - A case manager for the DSHS CPW program, which includes state staff and contracted providers, must be either a licensed RN or social worker.

  - In several other programs, including the DADS Home and Community-based Services (HCS) program, case managers are contracted provider employees and are required to have graduated from high school.

  - Some programs that use contracted providers for case management functions do not specify qualification requirements for case managers. For example, the state does not specify case manager requirements for ADRCs or AAAs.

Coordination and Knowledge Sharing Between Programs

One of the areas of focus of this study is the extent to which consumers have multiple case managers and the effect that this has on consumers. In both focus groups and surveys, consumers and case managers reported similar attitudes toward having multiple case managers, i.e., having more than one case manager is not necessarily viewed negatively by consumers and case managers. Consumers and case managers are both concerned, however, about duplication in the areas of intake and assessment.

Results from the consumer survey indicate that he percentage of consumers who had multiple case managers at the same time decreased considerably since those consumers started receiving services. The reduction in the percentage of consumers with multiple case managers is evident across all departments.

The results from the consumer and stakeholder groups and survey are mixed in terms of the effect that having multiple case managers has on consumers. For example, the majority of consumers surveyed did not indicate that having multiple case managers created difficulties for them. However, several focus group participants who reported having more than one case manager indicated that their case managers did not coordinate with each other and that they sometimes had to provide the same types of information to both case managers. A number of

these focus group participants also expressed the need for increased coordination between the different departments and programs serving them.

Case managers had attitudes similar to those of consumers regarding duplication and coordination of services. More than one-half of the case manager survey respondents indicated that they are serving consumers who have more than one case manager. Case managers reported in both the survey and focus groups that the most frequent types of case management activities "duplicated" are intake and assessment. Focus group participants also noted that other types of service duplication (outside of the intake and assessment process) are generally not an issue because case management services provided by different systems (e.g., behavioral health and aging and disability) are different in focus.

Based on the design and function of the program, the level of coordination between programs, departments and other organizations varies widely. For example:

- Due to the nature of the program service delivery, some programs have limited coordination with other HHS programs or outside resources like community or non-profit organizations. Nursing facilities, for example, tend to have limited coordination with other programs that provide case management; once an individual enters a nursing facility, the individual is typically disenrolled from other HHS programs. Coordination does occur when the resident is transitioned into a community setting.

- In some programs, coordination is central to the program. Many of the functions performed by ADRCs could be considered case management, because the goal of the ADRC program is to create a central access point into the long-term care system for consumers. ADRCs coordinate services with the regional DADS office, local MRAs and AAAs and non-profit and community organizations. Likewise the purpose of the DADS Relocation Assistance program could be considered case management. The function of the Relocation Program providers is to coordinate services among various state and community resources to assist individuals with successful re-entry to the community setting.

- In other programs, such as DSHS CPW and CSHCN, there is a high level of coordination with other HHS programs and outside resources.

- In many other programs, such as CLASS, there is some level of coordination with other programs and departments, but relationships are informal.

- There have been attempts to improve coordination across programs and departments. Although not a formal case management program, CRCGs, which are local groups that coordinate service plans across multiple agencies, provide a mechanism for multiple programs to coordinate an individual's care. The CRCGs

achieve many of the same objectives as case management, (e.g. connecting individuals with services), even though CRCGs are functionally different.

- In some circumstances, there is limited data-sharing regarding case management and other services among departments or even among programs within the same department. Case managers do not have a standardized method or access to a central database where they can determine what other services clients are receiving. Some advocates also noted that case managers may not know about other services their clients are receiving or may not know about available services outside of their program (e.g., community or non-profit organizations or other state or federal programs).

Case manager survey respondents and focus group participants both identified the need to improve coordination between different departments and programs. For example, nearly 70 percent of respondents reported that "insufficient service coordination across agencies" is a major or moderate problem. Focus group participants indicated that because of different operating procedures, terminology and levels of technology, they are not always familiar with what other departments and programs do.

Geographic Issues

Based on our review of case management program features, we found that case management services in rural areas are not designed differently than case management services in other areas of the state. Feedback from consumer focus groups, as presented in the following section, indicate that the cost of transportation in rural areas can be a challenge. Additionally, there is a perception that South Texas does not receive as much case management support (among other social services) as other areas in Texas.

Administrative Issues

It appears that direct service duplication is minimal; however, programs may be duplicating intake, eligibility and referral efforts. Many programs each separately perform these "front door" functions. There have been attempts to consolidate and streamline these efforts. For example, ADRCs provide a single point for consumers to access long-term services by providing intake, referrals, care coordination, case management and benefits counseling.

Satisfaction

Overall case manager and consumer satisfaction with the case management system is generally positive. For example, the majority of consumers surveyed were satisfied with their case manager and the case management services they have been receiving.

Some focus group participants, however, reported varying degrees of satisfaction with case management services. Many participants expressed satisfaction with the case management

services they receive. Those participants expressing dissatisfaction, expressed frustration with the lack of time and responsiveness of their case manager. Additionally, some participants expressed dissatisfaction with high case management turnover, with some participants citing the need to "train" the case manager about their child's needs. Many state program staff, with the exception of DARS and DSHS, also noted a concern regarding high case management turnover.

In general, case managers expressed satisfaction with the case management system in terms of the quality of services they are able to provide to their consumers. However, case managers who participated in both the focus groups and the survey expressed dissatisfaction with the availability and use of technology as well as with the amount of paperwork required of them. Many state program staff, with the exception of DARS and DSHS, noted a concern regarding high case management turnover.

Other Issues

Based on our review, we made the following observations around issues identified in the HHSC RFP:

- Program Risk Assessment. Based on our review of program information and preliminary findings from the stakeholder input process, it appears that there may be some modest amount of duplication of services. That duplication of services, if it does exist, appears to result from the structure of the programs that sponsor case management services. Our recommendations identify opportunities to minimize such risk to the program.

- Consumer Outcomes. We have reviewed some information about outcomes data currently measured and reported. It appears that many of the outcomes measures currently in use by the HHS case management programs relate to process outcomes (e.g. does the individual have an Individual Service Plan), rather than consumer outcomes. At this time we have limited program data regarding consumer outcome measures for case management services. The focus groups conducted as a part of this study will offer valuable information regarding consumer satisfaction and qualitative data regarding outcomes.

  HHS programs have taken steps towards measuring quality of case management services instead of process measures. For example, DADS Long Term Service and Supports 2006 Quality Review Report, which presents satisfaction results from the adult face-to-face experience and children/family mail surveys conducted by DADS in 2006, includes some case management-related indicators.

  - One of the indicators measured families' satisfaction with the "information and support necessary to plan for their services and supports." Respondents reported a moderate to high-level of satisfaction for all programs.

- Another group of indicators measured consumers' satisfaction with the accessibility and responsiveness of their service coordinator. The majority of respondents answered this group of questions favorably.

DADS expects that this data will allow for future program improvement and the capability to measure the impact of those improvements.

- Best Practices Used by Current Programs. The Texas HHS case management programs currently use several best practices. For example, the ADRC program attempts to create a single entry point for aged and disabled populations, with the goal of streamlining intake, eligibility and other functions, as well as reducing frustration and confusion on the part of the consumer. The Texas STAR+PLUS program is as an example of a successful program for long-term services coordination. Additionally, CRCGs help coordinate service plans for individuals across multiple agencies and community organizations.

  Examples of best practices currently used by Texas HHS programs are detailed in Navigant Consulting's Best Practices and Emerging Trends in Case Management report.

- Availability and Reliability of Consumer Data. Based on our review of consumer lists provided by the departments for use in the consumer telephone survey that is part of this project, contact information for current clients (i.e., name, address and phone number) is difficult to identify and often not reliable. [12] While the case file for a particular consumer might contain current and reliable contact information, this information is not readily transmitted or updated in the department's data systems. In some cases, reimbursement is not based on the accuracy of the related data fields and there is little incentive for providers to keep this information current for purposes of the department's data system.

Summary of Issues Identified by Stakeholders

During our focus groups with consumers and case managers and interviews with state program managers and staff and advocates, individuals discussed issues related to case management design, financing and delivery. There were some commonalities in these issues, as described in Exhibit 1 on the following pages.

[12] Several DARS and DSHS programs were not able to provide consumer lists due to consumer confidentiality and consent issues. To address this challenge, we established a toll-free number that consumers could call to register their interest in taking the survey and accepted consumer names directly from providers via fax.

Exhibit 1 provides the major themes that emerged during consumer and case manager focus groups and advocate interviews. We provide details and complete a summary of the interviews and focus groups in the Stakeholder Involvement Report.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Definition of Case Management	After some discussion about what case management means, it appeared that all participants had a common understanding of the term case management and could identify a case manager who works with them.	The participants offered their own definition of case management, as reflected in their own roles and functions. Many definitions included assessment, linkage to services, monitoring, advocacy, consumer empowerment and education. The frequency of case manager visits to their clients varied significantly by department and program. Reported caseloads also varied significantly (for example, from approximately 25 to 30 for ECI case managers to more than 200 for some DADS programs). Some case managers reported their large caseloads have made it more difficult for them to form deep relationships with their consumer and serve them more	Some programs report a more defined case management model might help with education about case management functions. There are nuances to case management that need to be refined. Some programs report that the only guidance is the State Plan. Some programs also report a need to define case management to include educational support or advocacy for the child to help the family.	Some advocates noted that there is little uniformity in the definitions of case management and suggested that standard definitions of case management, service coordination and other related services would be helpful.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Definition of Case Management, *Continued*		directly. Many participants expressed the need for more case managers. Case managers noted that their approach to working with consumers with special health needs is different from working with mental health and mental retardation consumers, in terms of Medicaid eligibility, case load, assessment and case management while on interest list.		

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Funding and Reimbursement	Consumers indicated that additional funding is needed to increase the availability of services that their case managers authorize for them. Some participants indicated that additional funding would allow their case managers to better perform their job responsibilities.	Some case managers noted general concerns regarding the adequacy of funding to provide services they authorize to the indigent and uninsured. In addition, some participants expressed their opinions that the salary scale for case managers in the public sector should be raised to compete with the private sector and that case load should be reduced by hiring more case managers.	Some department staff report concern regarding the adequacy of program funding and the relationships of funding to turnover, high caseloads and provider participation. Also of concern is the CMS review of targeted case management services and the requirement for billing in 15-minute increments; the impact of this billing requirement is unknown.	Several advocates noted concern regarding the adequacy of program funding and the relationships of funding to case manager turnover and high caseloads.
Resource Availability	Some participants indicated that they had difficulties receiving the necessary services that their case managers have authorized. Some noted that their case managers rarely call and do not ask what services they might need. Other consumers, however, indicated that their case manager enabled them to	Participants expressed concern with the high case manager turnover rate in the public system, attributing turnover to more stringent qualifications and lower pay. Participants also reported that they lose trained case managers to the private sector.	Many program staff, with the exception of DARS and DSHS, noted a concern regarding high case management staff turnover, which they attributed to high caseloads and low pay. DSHS has indicated that regional CPW and CSHCN programs have low staff turnover. Some programs report competition for case management staff with other social service agencies.	Some advocates expressed concern that high case manager turnover creates continuity issues for individuals. For example, one advocate noted that paperwork can be misplaced during staff transitions, which may delay access to needed services.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Resource Availability, *Continued*	access all of the services they needed. Some focus group participants stressed that case managers should be better informed about available resources and provide more information to consumers and families. Blind and visually impaired participants tended to report a positive experience regarding availability of services and with case management. Most participants reported that they wanted more time with their case managers. Some participants indicated that establishing eligibility and receiving authorization for services was sometimes difficult and time-consuming.	Some participants expressed the need for more bi-lingual case managers.	Additionally, some programs suggested that contracted providers do not take on case management for consumers with the most complicated needs. Some programs reported that case managers have difficulty identifying local services for their clients.	

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Knowledge Sharing about Services Received by Clients and Coordination Between Programs and Departments	Some participants noted that they (or their family members) had more than one case manager; these participants reported that the case managers did not coordinate; however, most participants reported having only one case manager. Some participants who had more than one case manager indicated that they sometimes need to provide the same types of information to both case managers. Some participants who had more than one case manager also identified the need for increased coordination between departments/agencies.	Case managers noted service duplication is not an issue because services provided by the behavioral health system are different in focus and interventions from services provided by the aging and disability system. Duplication exists in case managers from multiple systems performing the same functions for consumers with multi-system needs and repeated assessment of the individual as a result of lack of standardization. To determine appropriate access and make a case manager assignment for case coordination, each agency performs its own screening and assessment at the entry point.	Data-sharing is a major need reported by the HHS departments and programs. Most departments and programs report that case managers do not have the information they need about other services that clients are receiving. Many report that they rely on self-reported data from clients. Some departments and programs report minimal coordination. Many identified a need to increase coordination. Some programs expressed concern that clients would encounter a "wrong door" and subsequently be turned away for services. DSHS has indicated that CPW and CSHCN case managers coordinate services with other agencies and refer to other case managers when needed.	Some advocates noted that case managers may not know about other services their clients are receiving. Most noted that individuals have only one case manager and that duplication of case management services is not an issue. Several advocates noted that case managers may not know about available services outside of their program (e.g., community or non-profit organizations or other State or Federal programs).

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Knowledge Sharing about Services Received by Clients and Coordination Between Programs and Departments, *continued*	Some participants expressed the need for information on different programs and services to be more readily available and up-to-date. Many participants expressed frustration with long interest lists for some programs. They indicated that they were not offered case management services during this time and that it was their understanding that there were no other services available to address their children's needs. Some participants expressed frustration with staff from different programs not being familiar with the services the other provides.	All case managers reported experiencing barriers to linkage and monitoring functions due to inconsistent admission criteria, unavailability of services as a result of service gap or waiting list and lack of standardized protocols for referral. Because of different operating procedures, different terminology and different levels of technology, focus group participants indicated that they are not always familiar with what other programs and departments do. Some case managers indicated that the Community Resource Coordination Group (CRCG) program is a good model of how to coordinate services among departments and programs.	One department suggested that HHSC could provide more detailed guidance about case management. Additionally, participants noted that enhanced coordination among programs would help case managers identify community resources, since many clients across programs and populations use similar services. One department has already started a process to formalize information sharing about community resources.	

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Rural and Other Geographic Issues	Some consumers expressed a concern that there are fewer social services and options available in the Valley region as compared to other parts of Texas. Other consumers indicated concerns regarding transportation costs in rural areas and difficulty accessing services in general in those areas. Some consumers also cited difficulties in accessing transportation in urban areas citing, for example, long walks (over a mile) to a bus stop.	Case management staff indicated difficulties obtaining necessary services for consumers in rural areas. They also indicated that as a result of a scarcity of services in those areas, case managers often end up providing more direct care services and establishing a close working relationship with consumers. Case managers in rural areas indicated they spend a large portion of their time traveling because of the size of their services areas.	Some departments and programs report that rural areas are more difficult to service because of limited local resources and long travel distances. Programs also report that although the quantity of services is greater in urban areas, case managers may have some difficulty in identifying local resources.	Several advocates noted that services may be more difficult to obtain in rural areas.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Administrative Issues	Some consumers expressed frustration with lack of a central access point. Some participants indicated that they felt that paperwork takes away from the ability of their case managers to spend time with them (or their family members).	***Technology*** Availability and use of technology varies by department and program. In many of the departments and programs, case managers report that they do not have technology they can use in the field (i.e., during home visits) to record and transmit consumer information. Case managers, for the most part reported that they do not have laptops and typically need to record information on paper and then input the information into a computer later. Case managers reported that the DADS computer system is not reliable. The system is regularly down at the end of the month when case managers enter data into the system. Some case managers reported that because they are evaluated	Most department staff noted administrative difficulties in case management programs. Some programs suggested a system to standardize intake and assessment across all departments; another program has already begun an initiative to streamline processes.	One advocate noted that since the HHSC consolidation, there has been a general reduction of efficiency in program administration.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Administrative Issues, *Continued*		on efficiency if they are late entering data into the system, it reflects negatively on the case management statistics the department reports. Case managers reported that their computer systems are limited in their ability to identify the services their clients are receiving across all department and programs. ***Paperwork*** Many case managers reported feeling over-burdened with paperwork requirements and lack of face-to-face time spent with consumers. Some cited cases where documentation is duplicative, recorded first on paper and then electronically. Case managers indicated that they do not have clerical support, which could help		

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Administrative Issues, *Continued*		alleviate some of the burden. Case managers also reported that forms published by the departments change frequently, requiring them to go back to the consumer for his/her signature. Additionally, some focus group participants indicated that some forms are not available on-line and cannot be submitted on-line. ***Other*** Case managers reported that they comply with the State guidelines on required frequency of contacts for their clients and were able to manage the demand for monitoring. Some stated dissatisfaction with the administrative policies on monitoring methods.		

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Other Issues	Participants reported varying degrees of satisfaction with case management services. Some participants expressed dissatisfaction and frustration with case management services, specifically with the amount of time their case manager spent with them and the responsiveness of their case manager. Other participants reported positive experiences with case management services. Some participants expressed dissatisfaction with high case manager turnover in some programs. As a result, for example, some parents cited the need to "train" the case manager about their child's needs.	Participants noted that policies and procedures do not emphasize consumer outcomes; performance measures are mostly input measures. One case manager suggested use of peer counselors, but noted a lack of funding for such an initiative. One case manager noted that the practice of asking the consumer to complete a satisfaction survey in the presence of the case manager should be reconsidered.	No other issues identified.	One advocate noted that as programs consolidate, case managers may not be able to maintain population-specific expertise about the service needs of their clients. Some advocates expressed concern that conflicts of interest may occur if case managers are also providers of direct services. Other advocates indicated a conflict of interest may occur if case managers must advocate for clients against the organization employing the case manager. One advocate reports that Texas is known for having excellent services for individuals who are blind.

Exhibit 1: Summary of Stakeholder Feedback in Key Topic Areas

Key Topic Area	Consumer Focus Group Feedback	Case Manager Focus Group Feedback	State Program Manager and Staff Interview Feedback	Advocacy Organization Interview Feedback
Other Issues, *Continued*	Some participants noted difficulty with arranging transportation.			

D. Conclusion

The findings of our study support the information that is, for the most part, already known to Texas policymakers and stakeholders. Each department has multiple programs that provide case management services. Although many of these programs provide similar services to similar populations, the case management services have not developed with uniformity or consistency.

The HHS programs may have different funding streams, reimbursement methodologies, eligibility requirements, requirements for case managers and administrative structures. The programs have developed separately over time in response to the needs of the clients they serve, and to the demands of the funding mechanisms, which accounts for the variation between programs.

The variation between case management services across programs serving similar populations may create inefficiencies for HHSC and create service difficulties for HHSC clients. In addition, there may be potential for confusion on the part of providers, state staff and clients.

A review of the various HHS programs that provide case management services reveals that there is a variety of methods being employed. That same variety of methods is even evident across different programs within the same department. An understanding of the differences and similarities of case management among these programs will provide a good base as the state moves forward with its plan to optimize case management services throughout the state.

III. APPENDICES

- Appendix A presents details of the available claims and utilization data available for each program
- Appendix B presents total payments, unduplicated consumers, the unit rate of payment, average payment per consumer and average unit per consumer, specifically:
  - Appendix B.1: Department of Aging and Disability Services (DADS) programs
  - Appendix B.2: Department of Assistive and Rehabilitative Services (DARS) programs
  - Appendix B.3: Department of State Health Services (DSHS)
  - Appendix B.4: Department of Family and Protective Services (DFPS)
- Appendix C describes the source of available data used for this study.
- Appendix D details the results of Navigant Consulting's review of the Texas HHS programs that provide case management services, specifically:
  - Appendix D.1: Department of Aging and Disability Services (DADS) programs
  - Appendix D.2: Department of Assistive and Rehabilitative Services (DARS) programs
  - Appendix D.3: Department of Family and Protective Services (DFPS)
  - Appendix D.4: Department of State Health Services (DSHS)
- Appendix E describes programs that Provide Targeted Case Management
- Appendix F describes programs that Serve All Age Groups
- Appendix G describes programs that Serve Children
- Appendix H describes programs that Serve Adults Ages 18 to 21 and older
- Appendix I describes programs that Serve Adults Age 60 and older and Adults with Disabilities

Appendix A: Claims and Utilization Data Availability

Program	Claims Data	Utilization Data	Comments
Department of Aging and Disability Services (DADS)			
Aging and Disability Resource Center Pilot Sites	No	No	As these pilot sites have just begun, data are not available. These pilot sites anticipate tracking the number of contacts they have with consumers, but are not tracking whether or not the contacts are case management contacts. As such, they also are not tracking case management-specific expenditures.
Area Agencies on Aging	No	Yes	Providers are paid on a monthly or bimonthly basis for all services provided; no claims are submitted for individual services. Each AAA has its own client tracking system; AAAs can submit weekly requests for reimbursement to the state as well as Quarterly Performance Reports that detail unduplicated recipients, units of service and payments. These reports are stored electronically but there is no central database.
Community-Based Alternatives Program	No	No	State employees provide services so providers do not submit claims; Medicaid administrative match cost reimbursement is used (50/50 match).[13] 372 Federal waiver reports do not list expenditures or unduplicated consumers for case management services.

[13] We provide an explanation of administrative match in the Findings section of this report in the "Reimbursement, Funding and Utilization" subsection.

Appendix A: Claims and Utilization Data Availability

Program	Claims Data	Utilization Data	Comments
Community Care for the Aged and Disabled: • Primary Home Care • Community Attendant Services • Day Activity Health Services • Various Title XIX and State	No	No	State employees provide case management so providers do not submit claims; Medicaid administrative match cost reimbursement is used (50/50 match).
Department of Aging and Disability Services (DADS) Programs, *continued*			
Community Living Assistance and Support Services	Yes	No	Providers receive one fixed monthly payment amount for a minimum of one client contact; as such, the system does not capture how many encounters a client receives per month.
Consolidated Waiver	No	No	State employees provide services, so claims data are not available. Medicaid administrative match cost reimbursement is used (50/50 match). 372 Federal waiver reports do not list case management expenditures or unduplicated consumers.
Deaf/Blind with Multiple Disabilities Waiver	Yes	No	While providers bill for services per hour, the claims dataset received included the units variable but no unit values as the accuracy of the values could not be confirmed for purposes of the claims data provided.
Guardianship Program	No	No	Case management is not paid or recorded as a separate service; payments are made on a fee-for-service basis for each guardianship service type (i.e., Person only, Estate only, Person and Estate).
Home and Community-Based Services	Yes	Yes	Providers receive one fixed monthly payment amount for a minimum of one client contact; as such, the system does not capture how many encounters a client receives per month.

Appendix A: Claims and Utilization Data Availability

Program	Claims Data	Utilization Data	Comments
Intermediate Care Facility for the Mentally Retarded Services	No – case management is not paid or recorded as a separate service.		
Medically Dependent Children Program	No	No	State employees provide services so providers do not submit claims; Medicaid administrative match cost reimbursement is used (50/50 match). 372 Federal waiver reports do not list case management expenditures or unduplicated consumers.
Mental Retardation Local Authority Services	Yes (Medicaid only)	Yes	For targeted case management provided in an MRA setting, providers receive an interim rate per client per month which is then settled by the state annually based on cost reports.
Nursing Facility Services	No – case management is not paid or recorded as a separate service.		
Relocation Assistance for Individuals Transitioning from Nursing Facilities to Community Settings	Yes	Yes	Total number of contacts made is tracked, along with assessments, transitions and unsuccessful transitions.
Texas Home Living	Yes	Yes	None.
Department of Assistive and Rehabilitative Services (DARS) Programs			
Division for Blind Services – Blind Children's Vocational Discovery and Development Program	Yes	Yes	DBS tracks Medicaid billings and reimbursements. DBS bills one fixed monthly amount for a minimum of one client contact; as such, the system does not capture how many encounters a client receives per month.
Division for Early Childhood Intervention	Yes	No	ECI Service Coordination services other than targeted case management services are not paid with a unit rate and the costs cannot be isolated.
Vocational Rehabilitation	*Not included in analysis*		This report does not include any financial or utilization information related to the DARS' Vocational Rehabilitation programs through the Division for Rehabilitation Services and the Division for Blind Services. It does include information gathered from focus groups and interviews with program managers and staff.
Department of State Health Services (DSHS) Programs			

Appendix A: Claims and Utilization Data Availability

Program	Claims Data	Utilization Data	Comments
Children and Pregnant Women	Yes	Yes	A portion of case management services provided under the CPW program are paid through Medicaid administrative funds; no claims data are available for these services. Claims data are available for services provided by Medicaid enrolled CPW providers.
Children with Special Health Care Needs Services Program	No	No	None.
Mental Health -- Adult	Yes	Yes	Medicaid claims and encounter data are available.
Mental Health -- Child	Yes	Yes	
Department of Family and Protective Services (DFPS) Programs			
Adult Protective Services (APS)	No	Yes	DFPS reports case management-specific expenditures for its Medicaid population along with claimable units. While unduplicated consumers are reported by quarter, DFPS does not perform this calculation by year. While it is possible to determine APS- and CPS-specific expenditures, this process is administratively burdensome. DFPS does not report case management-specific expenditures and unduplicated consumers for its non-Medicaid funding streams. However, Medicaid consumers represent the majority of DFPS' case management services.
Child Protective Services (CPS)	No	Yes	

Appendix B.1: Payments and Utilization for the Department of Aging and Disability Services (DADS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006) **	Total Encounter Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Aging and Disability Resource Center Pilot Sites	Not available due to payment approach					
Area Agencies on Aging	• *Care Coordination:* 14,381 • *Caregiver Support Coordination:* Not available – collection of unduplicated consumer data is now required, effective FY 2007.	• *Care Coordination:* $78.22 • *Caregiver Support Coordination:* $89.70	• *Total:* $4,725,303 • *Care Coordination:* 3,345,560 • *Caregiver Support Coordination:* $1,379,743	• *Total:* 58,155 • *Care Coordination:* 42,773 • *Caregiver Support Coordination:* 15,382	• *Care Coordination:* $232.64 • *Caregiver Support Coordination:* Not available	• *Care Coordination:* 2.97 • *Caregiver Support Coordination:* Not available
Community-Based Alternatives Program	46,753	$55.78/month	$21,007,864	Not available	$449.34	Not available

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.1: Payments and Utilization for the Department of Aging and Disability Services (DADS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006) **	Total Encounter Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Community Care for Aged and Disabled: Primary Home Care	81,043	$17.54/month	$13,574,276	Not available	$167.49	Not available
Community Care for Aged and Disabled: Community Attendant Services	56,611	$29.82/month	$15,685,916	Not available	$277.08	Not available
Community Care for Aged and Disabled: Day Activity Health Services	22,964	$11.12/month	$2,494,661	Not available	$108.63	Not available
Community Care for Aged and Disabled: Various Title XX and State	47,804	$10.41/month	$5,279,994	Not available	$110.45	Not available
Community Living Assistance and Support Services	2,763	$175.11/month	$3,929,987	22,386	$1,422.36	Not available

Appendix B.1: Payments and Utilization for the Department of Aging and Disability Services (DADS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006) **	Total Encounter Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Consolidated Waiver	221	$147.75/month	$340,735	Not available	$1,541.79	Not available
Deaf/Blind with Multiple Disabilities Waiver	143	$37.09/hour	$249,865	6,470	$1,747.31	45.24
Guardianship Program	1,106	Not available	$248,661	Not available	$224.83	Not available
Home- and Community-Based Services	11,183 Of the total unduplicated HCS consumers, encounter data indicate approximately 3,691 were served in an MRA setting.	$214.83/ month	$26,161,138	While the HCS does not record specific encounters for all services, encounter data indicate approximately 23,948 hours of case management services were provided in an MRA setting to HCS consumers.	$2,339.37	While the HCS does not record specific encounters for all HCS services, HCS consumers receiving services in an MRA setting received an average of 6.5 hours of case management services.

Appendix B.1: Payments and Utilization for the Department of Aging and Disability Services (DADS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006) **	Total Encounter Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Intermediate Care Facility for the Mentally Retarded Services	7148 total in ICF/MR settings – while it is not known how many of these consumers receive case management services, approximately 502 ICF/MR consumers received case management services in an MRA setting.	Not available due to reimbursement methodology – for the 502 ICF/MR consumers receiving case management in an MRA setting, 2,589 hours of service were provided (5.2 average hours per consumer per year)				
Medically Dependent Children Program	1,523	$87.70/month	$1,158,692	Not available	$760.80	Not available
Mental Retardation Local Authority Services	11,152	$174.26/month	$22,531,818	Not available	$2,020.43	Not available
Nursing Facility Services	93,963 total in nursing facilities -- an unknown portion of these consumers receive case management services.	Not available due to reimbursement methodology				

Appendix B.1: Payments and Utilization for the Department of Aging and Disability Services (DADS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006) **	Total Encounter Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Relocation Assistance for Individuals Transitioning from Nursing Facilities to Community Settings	Not available	Not available	$1,185,465.50 (FY 2006)	11,190 contacts (FY 2006)	Not available	Not available
Texas Home Living[14]	1,561 .	$174.26/month	$2,963,117	Not available	$1898.22	Not available

[14] Targeted case management is not provided through the TxHmL program; MRAs provide case management services to individuals who are enrolled in TxHmL.

Appendix B.2: Payments and Utilization for the Department of Assistance and Rehabilitative Services (DARS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Division for Blind Services – Blind Children's Vocational Discovery and Development Program	3,021 (approximately 67 percent are Medicaid-eligible)	$59.81 per contact	$224,501 (Medicaid targeted case management only)	Not available	$110.92 (total Medicaid targeted case management expenditures divided by 67 percent of total unduplicated consumers)	Not available
Division for Early Childhood Intervention	45,901 This count is for comprehensive services within the ECI program.	$141.83 (Medicaid targeted case management)	$8,063,4356 (Medicaid targeted case management only)	Not available	Not available	Not available
Vocational Rehabilitation	*Excluded from data analysis*					

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**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.3: Payments and Utilization for the Department of State Health Services (DSHS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Mental Health – Adults	• *Total:* 32,968 • *Medicaid:* 21,415	$16.21 per 15 minutes of services	*Total:* $7,788,548 *Medicaid claims data:* $2,725,970 (calculated to include State and Federal share payments) *Estimated Non-Medicaid:* $5,062,578 For the purposes of this study, the Medicaid rate was applied to the non-Medicaid service encounters to estimate payments for non-Medicaid clients.	546,044 units (15 minutes of services), per encounter data • 233,732 for Medicaid consumers • 312,312 for non-Medicaid consumers	$236.25	4.5 hours *Note:* For Routine Case Management and Intensive Case Management, an "encounter" is defined as face-to-face provision of the service and does not include phone contacts and contacts with collaterals.

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.3: Payments and Utilization for the Department of State Health Services (DSHS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Mental Health – Children	• *Total:* 17,550 • *Medicaid:* 14,419	*Routine* -- $19.61 per 15 minutes *Intensive* -- $31.33 per 15 minutes	*Total:* $12,662,962 *Medicaid claims data:* $7,943,665 (calculated to include State and Federal share payments) *Estimated Non-Medicaid:* $4,719,297[15] For the purposes of this study, the Medicaid rate was applied to the non-Medicaid service encounters to approximate payment per unit of	545,649 units (15 minutes of services), per encounter data: • 333,896 for routine case management • 205,212 for intensive case	$721.54[16]	9.5 hours *Note:* For Routine Case Management and Intensive Case Management, an "encounter" is defined as face-to-face provision of the service and does not include

[15] Excludes costs for family case management.

[16] Excludes costs for family case management.

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**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.3: Payments and Utilization for the Department of State Health Services (DSHS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Mental Health – Children, *continued*			service to non-Medicaid clients.	management • 6,541 for family case management • 333,934 for Medicaid consumers • 206,714 for non-Medicaid consumers		phone contacts and contacts with collaterals.

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.3: Payments and Utilization for the Department of State Health Services (DSHS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Children and Pregnant Women	• *Total:* 10,046 • *Medicaid claims data:* 5,002 per claims data received on April 4, 2007 • *Regional staff:* 5,044 consumers receiving services	$54.48 for face-to-face contacts (wide majority of services) $18.00 for telephone contacts	• *Total:* $5,015,550 • *Medicaid claims data:* $1,639,620 • *Regional staff expenditures:* $3,375,930	28,172 (Medicaid claims data – no date of service data available for services provided through Medicaid funds)	$499.25 (using claims data and regional staff data)	5.6 (Medicaid claims data)

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.3: Payments and Utilization for the Department of State Health Services (DSHS), by Program

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Children with Special Health Care Needs Services Program	• *Total:* 14,569 • *Regional staff CSHCN case management:* 10,384 • *CSHCN SP contracted services:* 4,185	Not applicable due to reimbursement methodology; the average cost per CSHCN client receiving case management per year is $220.12	• *Total:* $5,396,161 • *Regional staff CSHCN case management:* $4,474,959 • *CSHCN SP contracted services:* $921,202 (estimated using the DSHS unit rate multiplied by unduplicated consumers)	Not available	$220.12	Not available

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.4: Medicaid Payments and Utilization for the Department of Family and Protective Services (DFPS)

Note: Non-Medicaid data are not available as DFPS does not break out case management service separately for non-Medicaid funding sources.

Program	Unduplicated Consumers Per Year (FY 2006)	Unit Rate*	Total Annual Case Management Payments (FY 2006)**	Total Units (FY 2006)	Average Payment Per Consumer (FY 2006)	Average Units Per Consumer (FY 2006)
Adult and Child Protective Services	• *Total* – 102,498 • *CPS* – 62,674 (FFY 2006) • *APS* – 39,824 (FFY 2006) (defined using the unique combination of state program and stage type for a TDFPS client ID with dates of service within federal FY2006)	$497.33 to $678.28[17]	$174,080,651 (FFY 2006)	289,518 (number of valid client contacts or collateral contacts about a client)	$1,698.	2.82

[17] Indicates range of unit cost rate per quarter for Federal Fiscal Year 2006.

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix B.4: Medicaid Payments and Utilization for the Department of Family and Protective Services (DFPS)

Note: Non-Medicaid data are not available as DFPS does not break out case management service separately for non-Medicaid funding sources.

*In the programs where State staff provide case management services, the Unit Rate is not a payment to the case management provider. It is the estimated cost of providing a unit of case management services.

**In the programs where State staff provide case management services, the Total Annual Case Management Payments and Average Payment per Consumer may reflect estimated case management staffing costs as opposed to payments to the case management provider.

Appendix C: Data Sources Used in Report

Program	Data Source
Department of Aging and Disability Services (DADS) Programs	
Aging and Disability Resource Center Pilot Sites	No data available on case management.
Area Agencies on Aging	Total payments, number of clients, units of service and amount paid per Agency on Aging, provided by Joy Modawell from DADS via electronic mail on April 3, 2007.
Community-Based Alternatives Program	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007.
Community Care for the Aged and Disabled • Primary Home Care • Community Attendant Services • Day Activity Health Services • Various Title XIX and State	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007.
Community Living Assistance and Support Services	Total FY 2006 annual consumers, expenditures, units and unit rate provided by Gerardo Cantu on April 18, 2007. Payments are for FY 2006 as of March 31,2007
Consolidated Waiver	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007.
Deaf/Blind with Multiple Disabilities Waiver	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007. Per the information provided, the unduplicated consumer count is estimated by assuming an annual turnover rate of 3.5 percent added to the highest monthly caseload in FY 2006.
Guardianship Program	Number of unduplicated wards for FY 2006 provided via electronic mail on April 2, 2007 by Gerardo Cantu.

Appendix C: Data Sources Used in Report

Program	Data Source
Department of Aging and Disability Services (DADS) Programs, *continued*	
Home- and Community-Based Services	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007. Navigant Consulting received encounter data extracted from the Mental Retardation and Behavioral Health Outpatient (MBOW) data warehouse by Mark Layne on April 4, 2007. We used this data to identify the number of Texas Home Living consumers provided services in a MRA setting.
Intermediate Care Facility for the Mentally Retarded Services	The number of consumers and payments for case management services in these settings are not recorded as these providers are paid a per diem rate that encompasses all services received. Total FY 2006 annual consumer counts provided by Gerardo Cantu on April 18, 2007. Navigant Consulting received encounter data extracted from the Mental Retardation and Behavioral Health Outpatient (MBOW) data warehouse by Mark Layne on April 4, 2007; this data contained encounters for ICF/MR residents in an MRA setting.
Medically Dependent Children Program	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007.
Mental Retardation Local Authority Services	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007. Per the information provided, the unduplicated consumer count is estimated by assuming an annual turnover rate of 3.5 percent added to the highest monthly caseload in FY 2006.
Nursing Facility Services	The number of consumers and payments for case management services in these settings are not recorded as these providers are paid a per diem rate that encompasses all services received. Total FY 2006 annual consumer counts provided by Gerardo Cantu on April 18, 2007. Navigant Consulting received encounter data extracted from the Mental Retardation and Behavioral Health Outpatient (MBOW) data warehouse by Mark Layne on April 4, 2007; this data contained encounters for ICF/MR residents in an MRA setting.

Appendix C: Data Sources Used in Report

Program	Data Source
Relocation Assistance for Individuals Leaving Nursing Facilities	Information received from Rosalin Willis via email on April 17 and 19, 2007.
Texas Home Living	Total FY 2006 annual consumers, expenditures and unit rate provided by Gerardo Cantu on April 18, 2007. Per the information provided, the unduplicated consumer count is estimated by assuming an annual turnover rate of 3.5 percent added to the highest monthly caseload in FY 2006. Navigant Consulting received encounter data extracted from the Mental Retardation and Behavioral Health Outpatient (MBOW) data warehouse by Mark Layne on April 4, 2007. We used this data to identify the number of Texas Home Living consumers provided services in a MRA setting.
Department of State Health Services (DSHS) Programs	
Children and Pregnant Women	Medicaid claims data provided by Cossy Hough, received April 2, 2007. Regional staff expenditure data provided by DSHS budget, received March 23, 2007. List of clients seen by regional staff in FY 2006, provided by Cossy Hough. List of clients provided services by regional staff for the second quarter of Fiscal Year 2007, received April 2, 2007
Children with Special Health Care Needs Services Program	Regional staff expenditure data provided by Cossy Hough, received March 23, 2007. Unduplicated consumer data provided by Penny Kendall, received April 18,2007. DSHS Survey Document.
Mental Health – Adult and Child	Medicaid claims data received April 4, 2007. Encounter data received on March 24, 2007 (analysis only includes records with general revenue, Medicaid and self-pay as the first billed payer).

Appendix C: Data Sources Used in Report

Program	Data Source
Department of Assistive and Rehabilitative Services (DARS) Programs	
Division for Blind Services – Blind Children's Vocational Discovery and Development Program	Monthly Medicaid and non-Medicaid consumer data received from Melinda Rivera on March 23, 2007. Total expenditures for targeted case management services received from Melinda Rivera on April 16, 2007.
Division for Early Childhood Intervention	Total FY 2006 annual consumer counts and TCM payments provided by Neomi Read on April 18, 2007. Total Annual Case Management Payments: data from the ECI Financial Status Reports submitted by ECI programs on a quarterly basis.
Division for Vocational Rehabilitation	Not applicable – not included in analysis
Department of Family and Protective Services (DFPS)	
Adult and Child Protective Services	Quarterly summary of the number of claimable units, unit cost, computable payments and net federal share for FFYs 2005 and 2006 provided by Beth Cody on April 5, 2007. Encounter data from Gilberto Cedillo, via Larry Swift, received on April 10, 2007..

Appendix D.1: Case Management Program Summary: Department of Aging and Disability Services (DADS)

Aging and Disability Resource Center Pilot Sites	
Program Description	The Aging and Disability Resource Center (ADRC) grant program is a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) designed as part of a national effort to restructure services and supports for older adults and persons of any age with one or more disabilities. Texas is one of 43 states that received competitive grants since the program began in 2003. Texas has three pilot sites: Alamo Service Connection, serving Bexar County, the Central Texas ADRC serving Bell, Coryell, Hamilton, Lampasas and Milam counties and the Tarrant County ADRC serving Tarrant County. The three ADRCs service consumers age 60 and over and individuals of any age with physical disabilities, mental retardation or developmental disabilities. ADRCs serve as integrated points of entry into the long-term care system or a "one-stop shop" for consumers at the community level. They are designed to improve access to services including both public benefits and privately funded services. Improved access may include standard intake and referral protocols, as well as the provision of care coordination, case management and benefits counseling. The intention of the ADRC program is to address some of the barriers that consumers and their families experience when trying to access needed long-term care information and services.
Service Definition	The ADRC program provides a specific function known as "system navigation." System navigation is not required by the grant; Texas provides this as an additional service. System navigation includes providing education and information, referral, benefits and options counseling, application assistance, care coordination, service brokering and advocacy. The system navigator serves as: • An assistant to individuals and their families who desire to remain in the local community. • A liaison with local agencies, organizations and providers of long-term services and supports. • A resource for individuals about all available health and human

Aging and Disability Resource Center Pilot Sites	
Service Definition, *continued*	services programs, formal and informal, public and private, to include providing assistance with eligibility requirements and application processes. • A resource to provide assistance, as appropriate, to all other "access" personnel (e.g., care coordinators and benefits and options counselors) in the development of person/family-directed transition plans and arrangements for the consumer and his family. The system navigation tasks include: • Meeting with referred individuals or individuals seeking services. • Assessing, in tandem with the individual and applicable family members, strengths, preferences and needs of the individual. • Locating traditional and non-traditional resources. • Making referrals to and linking the consumer with appropriate community based services as needed. • Assisting individuals with overcoming eligibility barriers. • Remaining involved with the individual to help ensure the service system is understood and the individual is not in need of other services to meet identified needs.
1915(c) Waiver Service	No.
Delivery Model	ADRC staff provide case management/system navigation services.
Coordination With Other Agencies	Collaboration and coordination are formally negotiated written agreements. The ADRCs coordinate services with the regional DADS office, local MRAs and AAAs and non-profit and community organizations. The Central Texas ADRC and Tarrant County ADRC physically co-locate staff from some partner organizations. The Alamo Service connection (Bexar County) plans to co-locate some partner organizations by the third year of the grant.

Aging and Disability Resource Center Pilot Sites	
Case Manager Qualifications	The state does not specify system navigator qualifications for ADRCs, although it does require the ADRCs to report system navigator qualifications.
Program Funding Source(s)	ADRCs are funded through a grant from AoA and CMS, with local matching funds.
Reimbursement Methodology	ADRC sites receive a lump sum for all development activities and service provision. Reimbursement is requested by the projects as needed. The ADRCs do not submit claims for their services.
Performance Measures	ADRCs must submit semi-annual reports to the state and to AoA and CMS. Alamo Service Connection (Bexar County) submitted its second report in April 2007; the other ADRCs submitted their first reports in April 2007. ADRCs reported: • Budget • Staffing • Number and type of contacts • Contacts by referral source • Number and type of unduplicated clients • Number and type of services and referral provided In addition to the Federal requirements, the state requires ADRCs to submit quarterly status reports on the implementation of their approved workplans.
Claims Systems/Databases	Each ADRC has its own client management system. ADRCs submit summary semi-annual reports to the state. These reports are summary level reports and do not contain client-specific demographic or service information. The state does not store the information in a database.

Area Agencies on Aging (AAAs)	
Program Description	AAA programs are aimed at helping people 60 years of age and older maintain their health, personal independence, dignity and ability to contribute to society. Each AAA establishes and maintains a system of access and assistance. The program incorporates necessary strategies and activities to meet the following goals: • To provide persons age 60 years and older efficient access to needed services. • To conduct effective screening and assessment of individual needs and preferences. • To efficiently and effectively target resources so that persons most in need receive assistance; and to establish a strong local role and clear identity of the area agency on aging as a source of access and assistance for eligible persons and/or their family members or other caregivers.
Service Definition	"Care Coordination" is an ongoing process including assessing the needs of a consumer and effectively planning, arranging, coordinating and following-up on services which most appropriately meet the identified needs as mutually defined by the consumer, and where appropriate, a family member or other caregiver and AAA access and assistance staff. The operational design of care coordination is dictated by the needs of the area agency on aging service area and includes a combination of levels of care. These levels of care coordination include: • Service authorization without an assessment - Must be used to procure all services except home-delivered meals, homemaker, personal assistance, residential repair and respite services. May be performed by any area agency on aging-approved access and assistance staff member either by phone or in person. Service authorization without an assessment must be based on a client intake completed by area agency on aging access and assistance staff or by a qualified source and the need for the identified service must be documented in the case

Area Agencies on Aging (AAAs)	
Service Definition, ***continued***	narrative. • Service authorization requiring an assessment - Must be used to procure home-delivered meals, homemaker, personal assistance, residential repair and respite services. May be performed by any area agency on aging-approved access and assistance staff member either by phone or in person. In addition to completing the client intake and nutritional risk assessment (home-delivered meals), a functional assessment must be conducted and must include all components and scoring procedures of the RLS Form 2060. Area agency on aging access and assistance staff may conduct the assessment, procure it or accept it from a qualified source. • Care Management – Care management services may be provided only to persons age 60 years and older and/or his/her family member or other caregiver, with priority given to those who have recently suffered a major illness or health care crisis or have recently been hospitalized and need additional attention during the recuperation period, those who live in a rural area, those who are moderately to severely impaired in activities of daily living and instrumental activities of daily living, those who have insufficient caregiver support or those who are in great economic or social need, particularly low-income, minority older persons. Care management must include the following: ➢ Comprehensive client assessment ➢ Care plan development ➢ Service authorization and arrangement ➢ Monitoring/follow-up activities ➢ Reassessment ➢ Maintenance of client case records Care management may not be provided by any entity with a vested interest in the delivery of services purchased by the area agency on aging without an approved waiver from the department. The average caseload is 90:1.

Area Agencies on Aging (AAAs)	
1915(c) Waiver Service	No.
Delivery Model	Care coordination is provided mainly as a direct service of the AAA. In some cases and in remote areas, AAAs may contract with nurses, social workers or other organizations to complete assessments.
Coordination With Other Agencies	Care coordinators are responsible for the client's total plan of care. There is a high level of coordination with other state programs as well as with community services, volunteer and faith-based organizations. The AAAs most frequently coordinate with the Community Based Alternatives (CBA) and Community Care for the Aged and Disabled (CCAD) programs. The AAAs may provide services to individuals who are on interest lists for other DADS programs.
Case Manager Qualifications	The state does not mandate qualifications for care coordinators. Qualifications for care coordinators vary among AAAs. A professional code of conduct for case managers is found in 40 TAC §83.3(o)(2)(C)(ii)(VIII).
Program Funding Source(s)	State General Revenue, Title III-B, Title III-D and Title III-E of the Older Americans Act, Local Matching Funds and Program Income.
Reimbursement Methodology	Care Coordination is provided through the AAAs and is cost-based. Reimbursement to the provider is made monthly or bi-monthly (depending on the contract) for the services delivered.
Performance Measures	Agency performance measures: • Annual unduplicated number of consumers served • Annual cost per unduplicated consumer • Cost per unit Federal funding performance measures:

Area Agencies on Aging (AAAs)	
Performance Measures, ***continued***	• Unduplicated number of consumers and demographic data • Units of service provided • Total service expenditures • Title III expenditures • Program income received
Claims Systems/Databases	• Each AAA has its own client tracking system; AAAs can submit weekly requests for reimbursement to the state as well as Quarterly Performance Reports that detail unduplicated recipients, units of service and payments. These reports are stored electronically but there is no central database.

Community-Based Alternatives Program (CBA)	
Program Description	The Community-Based Alternatives (CBA) program is a 1915(c) Medicaid home and community-based services waiver program for persons age 21 and older who would qualify medically and financially for nursing facility care. The goal of the CBA program is to provide individuals with meaningful choices for community long-term care services by facilitating the development and utilization of services that allow individuals to avoid premature nursing facility placement and provide current nursing facility residents an opportunity to return to the community. Individuals receive services through the CBA program and through other non-waiver service providers that are necessary to provide a safe alternative to nursing facility placement.
Service Definition	Case managers: • Determine eligibility • Assess and re-assess needs • Develop the individual service plan (ISP) for waiver and nonwaiver services • Authorize waiver services • Participate in utilization review activities, as needed • Monitor the appropriateness and quality of services • Provide crisis intervention and advocacy • Safeguard individual rights • Keep records • Coordinate and consult with service providers • Locate available resources and informal networks in the community • Work directly with the participant and his/her family

Community-Based Alternatives Program (CBA)	
Service Definition, ***continued***	Caseload ranges from approximately 200 to 300 clients per case manager.
1915(c) Waiver Service	CBA is a 1915(c) waiver program, but case management is provided by Community Care for the Aged and Disabled (CCAD), not billed through the waiver.
Delivery Model	Case management for the CBA program is provided by DADS staff.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program. CBA service plans are developed and referred to contracted providers who deliver CBA services. Case managers also ensure non-waiver services are included in the consumer's service plan by making referrals and assisting the consumer in obtaining available benefits. Non-waiver services include services provided by or funded by the applicant, guardian or family member, third-party resources (Medicare and Medicaid) and other private or government programs, such as Veterans Administration Aid and Attendance/Home Bound Benefits and programs for persons with mental illness or mental retardation. Case managers are required to report allegations of abuse, neglect or exploitation to DFPS and coordinate service plans to ensure health and safety.
Case Manager Qualifications	Case managers must have experience as a case manager for Community Care for the Aged and Disabled, Medicaid for the Elderly and People with Disabilities, Texas Works or Hospital Based services; knowledge of gerontology, the aging process and special problems of the aged and individuals with disabilities are preferred. Case managers must be able to communicate effectively, interview clients, understand and apply a variety of interrelated policies and establish priorities and manage time efficiently. No registrations, licensure requirements or certifications are required.
Program Funding Source(s)	Medicaid.

Community-Based Alternatives Program (CBA)	
Reimbursement Methodology	The program receives Medicaid administrative match (50/50) for case management services.
Performance Measures	Community Care Case Reading System (CC CRS), an automated application, serves as the basis of determining compliance with performance standards for individual case managers, regions and the state. CC CRS automates and standardizes the random sample selection of CBA cases and ensures results are reported consistently across individual staff, units and regions. Sample selections are read according to established guidelines and timelines. Performance standards include: • Eligibility • Timeliness of response to request for services • Timeliness of eligibility determination, re-determination changes • Timeliness and integrity of database • Consumer rights • Service plan authorization • Monitoring
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System data base in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. The DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data.

Community Care for the Aged and Disabled (CCAD)	
Program Description	• Community Care for the Aged and Disabled (CCAD) is a group of services purchased by DADS that provide care and support in the home or community to aged or individuals with disabilities who are not self-sufficient and who might otherwise be subject to unnecessary institutionalization or to abuse, neglect or exploitation. • The CCAD program includes Primary Home Care (PHC), Home-Delivered Meals, Family Care Services, Community Attendant Services, In-Home and Family Support Program, Adult Foster Care, Consumer Managed Personal Assistant Services, Day Activity and Health Services, Emergency Response Services, Residential Care and Special Services to Persons with Disabilities.
Service Definition	Case management clients must meet the eligibility criteria for CCAD services, but do not have to receive services to receive case management. Case management in CCAD is a direct assistance to consumers in managing the services that have been mutually planned and that use the consumer's own resources as well as community resources. The services are planned to enable the individual to carry out activities of daily living and to continue living in the community. Case management services include: • Intake — Requests for service or information are made by a consumer or someone on the consumer's behalf. • Assessment — Case managers respond to intake by visiting the person at home or other setting to conduct a face-to-face assessment of eligibility and needs. • Service planning — After completing the assessment, case managers develop a service plan with each eligible consumer. • Service authorization – Medicaid and non-Medicaid DADS services purchased as part of the service plan.

Community Care for the Aged and Disabled (CCAD)	
Service Definition, ***continued***	• Service monitoring and evaluation. Caseloads range from approximately 200 to 300 clients per case manager.
1915(c) Waiver Service	No.
Delivery Model	DADS staff provides case management services for CCAD programs.
Coordination With Other Agencies	There is a high degree of referral and coordination to other programs. Case managers evaluate consumers' needs for services and make referrals based on each individual's personal needs. CCAD case managers refer clients to any of the appropriate DADS, DARS, DSHS and DFPS programs as well as to services provided by local, county or city agencies and non-profit organizations. Most frequently, case managers refer clients to the CBA program or to CCAD attendant care programs such as PHC and Family Care. Case managers must also contact agencies as part of the eligibility determination or case management process. The most frequent contacts include: • Medicaid for the Elderly and People with Disabilities • Texas Works • Social Security Administration • Case managers are required to notify Adult Protective Services (APS) any time abuse, neglect or exploitation of an elderly person or individual with a disability is suspected. • Veterans Administration (VA) regarding eligibility for VA compensation, Aid and Attendance or Home Bound benefits. • Mental Health and Mental Retardation (MHMR) referrals are made when the case manager believes the consumer would benefit. Additionally, some services (e.g., In-Home and Family Support) are not available through DADS to

Community Care for the Aged and Disabled (CCAD)	
Coordination With Other Agencies, ***continued***	persons with MR or MI diagnoses and would require a referral to MHMR. • TMHP is consulted when the case manager is not able to obtain verification of medical necessity from any other source.
Case Manager Qualifications	The minimum requirements for a case manager position include the ability to communicate effectively, interview applicants/consumers, understand and apply a variety of interrelated policies, establish priorities and manage time efficiently. Knowledge of gerontology, the aging process and special problems of the aged and individuals with disabilities are preferable for persons applying for case manager positions. There are no degrees, registrations, licensures or certifications required.
Program Funding Source(s)	The program is funded through a variety of sources, including Title XX funds, Medicaid and pure State General Revenue. Medicaid is the primary funding source for most services.
Reimbursement Methodology	The program receives Medicaid administrative match (50/50) for case management services.
Performance Measures	The Community Care Case Reading System (CCCRS) contains information used to determine compliance with case manager performance standards. CCCRS automates and standardizes the random sample selection of CCAD cases and ensures results are reported consistently across individual staff, units and regions. Sample selections are read according to established guidelines and timelines. Performance standards include: • Eligibility • Timeliness of response to request for services • Timeliness of eligibility determination, re-determination and changes • Timeliness and integrity of database

Community Care for the Aged and Disabled (CCAD)	
Performance Measures, *continued*	• Consumer rights • Service plan authorization • Monitoring The case manager is also evaluated on additional parameters based on assignments designated by regional management.
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System database in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data.

Community Living Assistance and Support Services (CLASS)	
Program Description	The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as cost-effective alternatives to placement in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) /Related Conditions. There are two service providers for CLASS: one provides independent case management and the other provides all direct services. The CLASS model focuses on independence and integration into everyday community life
Service Definition	Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services, regardless of the funding source. Case managers initiate and oversee the assessment of the individual's level of care and the review of plans of care at such intervals as are specified. For example, case managers: • Follow uniform procedures for needs assessment and reassessment • Develop the service plan of care • Identify appropriate community resources • Monitor the appropriateness and quality of services • Provide crisis intervention and advocacy • Safeguard individual rights and keep records • Locate available resources and informal networks in the community Implementation of case management services involves coordination and consultation with other service providers and contacts with the individual and his/her family. The average caseload is 30:1.

Community Living Assistance and Support Services (CLASS)	
1915(c) Waiver Services	Yes.
Delivery Model	DADS contracts with 38 case management agencies which currently include two Mental Retardation Authorities (MRAs) and at least three providers who are also providers of HCS services. Contractors are selected through an RFP process.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program. Applicants self-report to DADS whether they have other services. Contractors do not have access to the DADS database that might show whether clients are receiving other services, although DADS does report to case management agencies information about other community services an applicant may be receiving. Relationships between other programs and services are informal.
Case Manager Qualifications	Case managers must be licensed by the Texas State Board of Social Work Examiners at the time of employment or no later than nine months after employment as one of the following: • A licensed Master's social worker or • A licensed Bachelor's social worker Alternatively, a case manager must have the formal education equivalent of a Bachelor's degree in a health and human services field plus two years of experience in the delivery of human services to persons with disabilities.
Program Funding Source(s)	Medicaid.

Community Living Assistance and Support Services (CLASS)	
Reimbursement Methodology	The monthly reimbursement is determined in the following manner: • Total allowable costs for each provider are be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information. • Total allowable costs are reduced by the amount of administrative expense fee revenues reported. • Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices). • Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA) and the Texas Unemployment Compensation Act (TUCA). • Each provider's projected total allowable costs are divided by the number of monthly units of service to determine the projected cost per client month of service. • Each provider's projected cost per client month of service is arrayed from low to high and weighted by the number of units of service and the median cost per client month of service is calculated. • The median projected cost per client month of service is multiplied by 1.044. Reimbursement for case management services is $175.11 per consumer per month for each month that a consumer receives case management services.

Community Living Assistance and Support Services (CLASS)	
Performance Measures	There are performance measures related to the contracted case management provider's compliance with program requirements including assessment and eligibility criteria, Individual Service Plan Development, measures related to Interdisciplinary Team and Individual Program Plan, reassessment, crises intervention and service delivery documentation. DADS staff reviews contractor compliance at least annually.
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System data base in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data.

Consolidated Waiver Program	
Program Description	The 1915(c) Consolidated Waiver Program is a pilot program authorized by Texas Government Code §531.0219 for the purpose of testing the feasibility of combining five of the state's 1915(c) Medicaid waiver programs, including CBA, CLASS, MDCP, HCS and DBMD. The pilot program is limited to serving 200 individuals in Bexar County. This program provides services to all age groups.
Service Definition	Case managers assist individuals who receive waiver service in gaining access to needed waiver and other state plan services. Case managers also assist individuals in gaining access to needed medical, social, educational and other appropriate services, regardless of the funding source, that will help an individual achieve a quality of life and community participation acceptable to the individual. The average caseload is approximately 50:1.
1915(c) Waiver Service	Yes.
Delivery Model	There are three case managers who are DADS staff.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program.
Case Manager Qualifications	Case managers must have: • Four years of experience as a Community Care Worker, CBA or Waiver Case Manager; or • Bachelor's Degree in Social Work or closely related field, plus six months of work experience as a case manager in social services. • Experience in: ➢ Performing casework, applying program knowledge,

Consolidated Waiver Program	
Case Manager Qualifications, *continued*	service skills, analyzing problems and providing advice or insight into solutions to problems ➢ Adapting or interpreting guidelines ➢ Developing and maintaining standards of service ➢ Evaluating service delivery to determine quality, accuracy and timeliness of services provided. ➢ Preparing reports and records to provide management information on program operations
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	The program receives Medicaid administrative match (50/50) for case management services.
Performance Measures	Measures developed related to quality of service evaluated in 2003 indicated high levels of satisfaction for both consumers and case managers. Service indicators: • Service costs • Program administration costs • Consumer satisfaction • Provider satisfaction • Service patterns • Other

Consolidated Waiver Program	
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System database in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data.

Deaf/Blind with Multiple Disabilities Waiver	
Program Description	The goal of the Deaf Blind with Multiple Disabilities (DBMD) Medicaid Waiver Program is to provide individuals who are deaf blind with multiple disabilities a choice of residential alternatives that maximize: • Independence • Communication • Interaction with the community To be a DBMD Medicaid Waiver client, a person must: • Be determined Medicaid eligible for waiver services • Be age 18 or older • Have the same level of care criteria established by the State of Texas to certify individuals eligible for ICF-MR/RC VIII services under the Title XIX State Plan • Not be enrolled in any other Medicaid waiver program • Not be a resident of either: ➢ Intermediate care facility ➢ Nursing facility ➢ Hospital • Be responsive to his/her living environment and • Be deaf blind with at least one other disability

Deaf/Blind with Multiple Disabilities Waiver	
Service Definition	Case Management includes services which will assist individuals who receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified. Case managers are responsible for ongoing monitoring of the services included in the individual's plan of care. They communicate with the interdisciplinary team members to ensure that the client's plan of care is being carried out appropriately and monitor the success of the plan of care by observing the participant at home and in the community. Case managers are service providers. The average caseload information is not available.
1915(c) Waiver Service	Yes.
Delivery Model	Contractors are obtained through an RFP process. 18 agencies provide services. Case management services are provided through employees of contracted provider agencies.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program. Case managers may interact with various agencies which serve consumers, including the State School for the Deaf, the Texas School for the Blind and Visually Impaired and the Department of Assistive and Rehabilitative Services Division for Blind Services – Deaf Blind Services and BSD.
Case Manager Qualifications	Case managers must: • Be licensed as one of the following by the Texas State Board of Social Work Examiners: ➢ Master's Social Worker - Advanced Clinical

Deaf/Blind with Multiple Disabilities Waiver	
Case Manager Qualifications, ***continued***	Practitioner (LMSW-ACP) ➢ Master's Social Worker - Advanced Practitioner (LMSW-AP) ➢ Master's Social Worker ➢ Social Worker ➢ Social work associate or • Have a Bachelor's degree in a health and human services related field, plus two years of experience in the delivery of human services to persons with disabilities; or • Have an Associate's degree in a health and human services related field, plus four years of experience in the delivery of human services to persons with disabilities; or • Have a high school diploma with six years of experience in the delivery of services to persons who are deaf, persons who are blind or visually impaired and those with multiple disabilities; and • Be fluent in the communication system used by the clients they serve. Communication systems include American Sign Language, tactual symbol communications systems and gestures. If a case manager is not fluent, he must have a communication training plan. The plan must result in the case manager being able to communicate fluently with the client within six months of serving the client.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	An allowable cost per unit of service is calculated for each contracted provider for each service. The allowable costs per unit of service for each contracted provider are arrayed. The units of service for each contracted provider in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and is multiplied by 1.044. The allowable costs per unit of service may be combined

Deaf/Blind with Multiple Disabilities Waiver	
Reimbursement Methodology, *continued*	into an array with the allowable costs per unit of service of similar services provided by other programs in determining the median cost per unit of service. Case management services are reimbursed at a rate of $37.09 per hour.
Performance Measures	Performance measures include measures related to assessment and eligibility criteria, Individual Service Plan Development, measures related to Interdisciplinary Team and Individual Program Plan and service delivery documentation. Additionally, the program has client outcome measures related to communication skills, active participation, choice, orientation and mobility and community participation.
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System data base in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data.

Guardianship Program	
Program Description	Guardianship is a legal process used to provide protection for adults who are incapacitated, as defined by the Texas Probate Code. The Probate Code defines an incapacitated individual as: "An adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing or shelter to himself or herself, to care for the individual's own physical health or to manage the individual's own financial affairs." The DADS Guardianship Program provides guardianship services, either directly or through contracts with local guardianship programs, to individuals referred to the program by either the Adult Protective Services (APS) or Child Protective Services (CPS) Divisions of the Texas Department of Family and Protective Services (DFPS). These services include: • Performing an assessment to determine if the individual has diminished capacity. • Identifying less restrictive alternatives to guardianship. • Trying to identify other individuals or organizations that are willing, able and appropriate to serve as guardian. • Preparing legal documents for presentation at court and presenting testimony in court as evidence to support petitions presented for court action.
Service Definition	Provide services either directly or through contracts with local guardianship programs to individuals age 18 and older who have been adjudicated incapacitated by a court of law and have disabilities and/or are aged. Services are not voluntary; clients are brought in through court order. The order from the court determines what duties the guardian will perform. Guardianship specialists perform the following services: • If court appointed guardian of the estate, locates, secures and manages a ward's estate.

Guardianship Program	
Service Definition, *continued*	• If appointed guardian of the person or guardian or the person and estate, ensures a ward has access to adequate care, protection and services based upon identified needs, service plan and the court order. • If appointed guardian of the person, makes medical decision about events such as major surgery and/or life – threatening illness. • If appointed guardian of the estate, conducts inventory appraisement and the list of claims and files inventory with court. Prepares and files an annual accounting with the court. • If appointed guardian of the person, prepares and files an annual report with the court. • If appointed guardian of the person and/or guardian of the estate, resolves issues or problems that affect the ward or their finances. • As much as possible, considers the ward's wishes and choices when making decisions about the ward. • Conducts monthly face-to-face visits with wards and maintains documentation about the visits. • As guardian of the person and or guardian of the estate, informs the appropriate DADS agency staff, including legal staff, of major issues involving wards or wards' finances and documents all actions in the ward's record. • Ensures that if cases are closed or transferred the court is notified, all reports are filed with the court within the required timeframes and documentation is complete and up to date. Desired caseload is 15:1.
1915(c) Waiver Service	No.

Guardianship Program	
Delivery Model	Eleven supervisors, 47 guardianship specialists and five guardianship accountants. Guardians for DADS wards are appointed by the courts and are either DADS employees or if contracted by DADS, the guardianship provider. The contracted guardianship provider does not conduct the assessment for capacity.
Coordination With Other Agencies	Wards can receive residential or care services through other agencies or groups. DADS contracts with five nonprofit guardianship agencies for guardianship services. The agencies are responsible for ensuring guardianship services are provided by qualified employees or volunteers. DADS' staff and contracted providers are required to be available 24 hours a day, 7 days a week, 365 days a year.
Case Manager Qualifications	Individuals serving in a guardianship capacity and contracted or employed with DADS as guardianship specialists must employ case managers that have a Bachelor's degree from an accredited college or university with one year of full time work experience in direct social service work or 60 hours from an accredited college or university and certification from the National Guardianship Association. After September 1, 2007, contractors and DADS must employ specialists that meet the criteria above and are also certified by the Texas Guardianship Certification Board. Anyone receiving compensation for providing guardianship services will be required to be a Registered Guardian through the National Guardianship Foundation and certified according to the standards of the Texas Guardianship Certification Board.
Program Funding Source(s)	Most wards are eligible for Title XIX or some other benefit. Wards must be able to pay for their own care. The DADS guardianship program is funded through Title XX. The contracted providers for DADS' guardianship services are funded through State of Texas General Revenue.

Guardianship Program	
Reimbursement Methodology	Guardianship services include case management, which is not paid for as a separate service. Payment is based on guardianship service type. Payments are made on a fee-for-service basis for each guardianship service type. Monthly rates range from $155.00 to $248.05 for Person only; $156.25 to $337.93 for Estate only and $156.25 to $424.32 for Person and Estate.
Performance Measures	DADS guardianship quality assurance (Oversight and Community Supports Unit) has oversight responsibility for the DADS guardianship program and DADS guardianship providers. Long Term Care Regulatory, Adult Protective Services (part of DFPS) and other regulatory entities have oversight of the services and residential placements of most of the DADS wards. DADS' guardianship staff and contracted providers of guardianship services are reviewed for compliance with guardianship rules, policies, procedures, program conditions and standards and compliance with the probate code.
Claims Systems/Databases	The guardianship program maintains an Excel database to capture ward demographic and payment information, but does not track case specific expenditures or utilization.

Home and Community-Based Services (HCS) Program	
Program Description	The HCS Program is a Medicaid waiver providing community-based services and supports to eligible individuals as an alternative to the ICF/MR Program. Services include case management; counseling and therapies provided by appropriately licensed professionals, nursing provided by licensed nurses; residential assistance, excluding room and board; respite, which includes room and board when provided in a setting other than the individual's home; day habilitation; supported employment; adaptive aids; minor home modifications; financial management services; and support consultation. Provides services to individuals of all ages.
Service Definition	Case management services assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care, the review of plans of care at such intervals as are specified and monitor provision and effectiveness of services. Caseload is restricted to 30:1.
1915(c) Waiver Service	Yes.
Delivery Model	Employees of HCS providers provide case management services. By statute, the case manager must refer all HCS services to the organization that employs the case manager.
Delivery Model	Case manager must be an employee of the program provider entity.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program. The case manager coordinates with other entities as necessary on an individual basis. Examples include ECI, public schools, DSHS and DARS.

Home and Community-Based Services (HCS) Program	
Case Manager Qualifications	Qualification requirements for individuals providing case management services include: • Graduation from an accredited high school or equivalent, plus two years of full time experience in social, behavioral or human services. Experience may be in capacity of full-time employee, contractor or volunteer or • Licensure as an RN or LVN and one year of full-time experience in social services, as indicated above or • A Bachelor's degree in social science, behavioral science or human services or • Graduation from an accredited high school or equivalent. These individuals may perform and submit claims for case management activities with the following limitation: they may not independently perform assessments or service planning. However, they may perform and submit claims for activities that support the gathering of information for the assessment and the formulation of a plan of care.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	Reimbursement for case management services is on a per client served per month basis at a rate of $214.83.
Performance Measures	Do not measure specific outcomes. If individual needs are not being met, they expect communication among individuals.
Claims Systems/Databases	Provider files claims through CARE system.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) Services	
Program Description	Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are operated by private or public entities and provide residential and habilitative services, skills training and adjunctive therapies with 24-hour supervision and coordination of the individual program plan. These residential environments range from six beds to several hundred beds for persons who have mental retardation or a condition related to mental retardation. There are two types of ICF/MR facilities: • State Schools are campus-based facilities that serve from 100 to 600 individuals who have severe or profound mental retardation or those individuals with mental retardation who are medically fragile. • Community-Based ICF/MR facilities are community-based residences that vary in size from less than eight individuals to more than fourteen individuals who have mental retardation and/or a related condition.
Service Definition	Case management services in an ICF/MR are included as part of the broader roles and responsibilities of the QMRP. Case Management services provided by a QMRP in an ICF/MR are designed to ensure that proper services are provided for the individual through the service plan and that there is ongoing monitoring and follow up to ensure service plans are implemented and carried out. The average caseload varies by facility.
1915(c) Waiver Service	No.
Delivery Model	Qualified Mental Retardation Professionals (QMRP) within ICFs/MR.
Coordination With Other Agencies	Interaction with other programs is limited and infrequent. Most services for residents are provided by the facility and are included in the facility's per diem rate.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) Services	
Case Manager Qualifications	QMRPs provide case management services in ICFs/MR. To be qualified as a QMRP, an individual must have a Bachelor's degree in human services and at least one year of experience working with persons with mental retardation or a related condition.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	Case management services provided to ICF/MR consumers are included in the overall per diem payment rate for ICF/MR services. There is no separate billing for case management.
Performance Measures	Annual surveys, review of state licensure compliance. Investigate QMRP roles when complaints are filed.
Claims Systems/Databases	Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. There is no system at the state that tracks information specific to case management services provided by QMRPs. The facilities do not track this information.

Medically Dependent Children Program (MDCP)	
Program Description	The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and to encourage de-institutionalization of children in nursing facilities.
Service Definition	Case Management services consist of: • Ensuring informed choices are made • Ensuring eligibility • Assessing and re-assessing needs • Developing the service plans for waiver and non-waiver services • Authorizing waiver services • Participating in utilization review activities • Monitoring the appropriateness and quality of services • Providing crisis intervention and advocacy • Safeguarding individual rights • Keeping records • Coordinating and consulting with service providers • Locating available resources and informal networks in the community • Working directly with the participant and his family to ensure quality service delivery The average caseload is 41:1.
1915(c) Waiver Service	Yes.

Medically Dependent Children Program (MDCP)	
Delivery Model	Case management services provided by DADS staff.
Coordination With Other Agencies	Applicants for this program cannot be in any other waiver program. Within the program, consumers select the providers to deliver MDCP services. Case managers coordinate service requests and delivery with a variety of contracted providers. Direct care available to program participants is delivered in the absence of the primary caregiver. Given the personal nature of MDCP direct care services, families participating in MDCP communicate directly with service providers. For related non-MDCP program services, case managers facilitate communication with the Medicaid agency for obtaining and maintaining Medicaid eligibility and Medicaid contractors for service requests and delivery of community-based Medicaid benefits within the State Medicaid Plan as needed. For services beyond those provided by the program, case managers provide program participants and their families with contact names and numbers for non-waiver services and assist as needed.
Case Manager Qualifications	MDCP case managers must be social workers licensed by the Texas State Board of Social Work Examiners or must have a Bachelor's Degree and two years experience serving children with special health care needs.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	The program receives Medicaid administrative match (50/50) for case management services.
Performance Measures **Performance Measures,**	Performance standards for case managers include: • Completes assessments according to established time

Medically Dependent Children Program (MDCP)	
continued	frames. • Coordinates effectively with MDCP nurse to ensure that home visits are conducted with the least amount of disruption and inconvenience to the family. • Evaluates, identifies and coordinates appropriate resources and programs available to the MDCP client. • Collaborates with MDCP nurse, family and client to identify appropriate long and short-term goals, including Permanency Planning and Inclusion. • Contacts family weekly until a decision is made on their choice of MDCP providers for service initiation. • Provides service authorizations to selected providers within five working days of notification by client. • Completed and finalized care plans are entered 30 days prior to expiration of current care plan. • Completes the care plan form in an accurate and legible manner. • Completes telephone contacts within 30 days of the effective date of the initial care plan. • Completes two telephone contacts within the care plan year, one within three months and the other within nine months. • Conducts six-month face-to-face monitor visits in coordination with the MDCP nurse to evaluate client status and satisfaction with services. • Documents monitoring information accurately and legibly. • Reports all cases of suspected injury, abuse and neglect to the appropriate authorities. • Coordinates with the client's physician as needed during the plan year.
Performance Measures, ***continued***	• Provides appropriate assistance and intervention to address problems encountered and reported by the client or other

Medically Dependent Children Program (MDCP)	
	sources. • Collaborates with MDCP nurse in completing Provider Documentation Compliance Review forms accurately during 6-month monitoring visits. • Informs provider of any deficiencies within 5 working days after receiving a provider deficiency notification. • Collaborates with MDCP nurse in developing corrective action plans. • Notifies state office program staff of all instances of provider non- compliance on Corrective Action Plans. • All duties are performed in a manner in which consistency, cooperation, respect and professionalism toward others is maintained. • Ensures that program rules are correctly presented.
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System database in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data. DADS does not maintain a database for case management services delivered by DADS employees and does not assign case management services to a claims system.

Mental Retardation Authority Services	

Program Description	Mental Retardation Authority (MRA) service coordination services are available to members of the mental retardation priority population who meet at least one of the following criteria:
	• Have two or more documented needs that require services and supports other than service coordination
	• Be in the process of enrolling in:
	  ➢ The HCS Program; or
	  ➢ The ICF/MR Program
	• Be in the process of enrolling in or currently enrolled in the TxHmL Program
	• Be seeking admission to a state MR facility
	• Be transitioning from an ICF/MR, including a state MR facility, to community-based mental retardation services and supports other than another ICF/MR or a nursing facility licensed in accordance with Texas Health and Safety Code, Chapter 242
	• Be transitioning from a state mental health facility to community-based mental retardation services and supports other than in an ICF/MR or a nursing facility licensed in accordance with Texas Health and Safety Code, Chapter 242
	The priority population for mental retardation services consists of individuals who meet one or more of the following descriptions:
	• Persons with mental retardation, as defined by Texas Health and Safety Code §591.003
	• Persons with pervasive developmental disorders, including autism, as defined in the current edition of the Diagnostic and Statistical Manual
	• Persons with related conditions who are eligible for services in Medicaid programs operated by the

Mental Retardation Authority Services	
Program Description, ***continued***	department • Nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to Section 1919(e)(7) of the Social Security Act • Children who are eligible for services from the Early Childhood Intervention Interagency Council The program serves all age groups, but most recipients are over three years of age.
Service Definition	Service coordination is assistance in accessing medical, social, educational and other appropriate services and supports that will help an individual achieve a quality of life and community participation acceptable to the individual (and legally authorized representative [LAR] on the individual's behalf) as follows: • Crisis prevention and management – Linking and assisting the individual and LAR or actively involved person to secure services and supports that will enable them to prevent or manage a crisis. • Monitoring – Ensuring that the individual receives needed services, evaluating the effectiveness and adequacy of services and determining if identified outcomes are meeting the individual's needs and desires as indicated by the individual and LAR or actively involved person. • Assessment – Identifying the individual's needs and the services and supports that address those needs as they relate to the nature of the individual's presenting problem and disability. • Service planning and coordination – Identifying, arranging, advocating, collaborating with other agencies and linking for the delivery of outcome-focused services and supports that address the individual's needs and desires as indicated by the individual and LAR or actively involved person. • Case managers initiate and oversee the process of assessment and assessment of the individual's needs and

Mental Retardation Authority Services	
Service Definition, ***continued***	the review of the service plan at such intervals as are specified. The current case management caseload varies by MRA, but the average is 40:1.
1915(c) Waiver Service	No.
Delivery Model	Case managers are employees of the MRAs that contract with DADS to be a provider of targeted case management services.
Coordination With Other Agencies	MRAs are responsible for admissions into ICF/MR, State School, HCS and TxHmL. MRAs are required to coordinate with other agencies and community organizations and coordinate services among providers. DADS staff and MRAs sometimes service the same client, although efforts are underway to reduce this duplication by providing MRAs access to DADS information resources.

Mental Retardation Authority Services	
Case Manager Qualifications	The qualifications for service coordinators are: • A bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral or human service field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education and criminal justice; or • A high school diploma or a certificate recognized by a state as the equivalent of a high school diploma and: ➢ Two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making; and ➢ Personal experience as an immediate family member of an individual with mental retardation. • The MRA, at its discretion, may require additional education and experience for staff who provide service coordination. • At the discretion of the MRA, a staff person who was authorized by an MRA to provide service coordination prior to April 1, 1999, may provide service coordination without meeting the minimum qualifications described above.
Program Funding Source(s)	Medicaid. State General Revenue for non-Medicaid consumers.
Reimbursement Methodology	Case management services are reimbursed at an interim rate per client per month and settled annually based on cost reports.

Mental Retardation Authority Services	
Performance Measures	Each MRA must meet its quarterly target for service coordination. For example, the MRA for Tarrant County is required to provide service coordination to an average of at least 680 individuals per month for each quarter. The Contract Accountability and Oversight Unit in the MRA Section of Access and Intake at DADS, conducts an annual review of each MRA. The review covers verification of service coordinators' qualifications, required training and compliance with Service Coordination rules. A report titled "Potential Lost Medicaid" is available to MRAs and lists consumers who are incorrectly identified as not eligible for Medicaid to ensure proper billing for Medicaid-covered service coordination. DADS uses the report to ensure an MRA is properly billing for Medicaid-covered service coordination.
Claims Systems/Databases	Record services on a Service Data form. Report encounters.

Nursing Facility	
Program Description	Nursing facilities provide room and board, institutional services and medical and nursing facility services in the form of nursing care to residents.
Service Definition	Nursing facilities hire social workers who assist residents in maintaining or improving their ability to manage their everyday physical, mental and psychosocial needs. Case management services provided by social workers in nursing facilities include: • Obtaining needed adaptive equipment • Maintaining contact with the family • Making referrals and obtaining services • Assisting with financial and legal matters • Discharge planning • Others The facility must provide medically-related social services to attain the highest practicable physical, mental or psychosocial well-being of each resident. In addition, the Minimum Data Set (MDS) assessment coordinator performs the MDS assessment. The care plan is based on the MDS assessment. No recommended caseload. If more than 120 beds, nursing facility must employ social worker. If less than 120 beds, nursing facility can contract with a social worker.
1915(c) Waiver Service	No.

Nursing Facility	
Delivery Model	Social workers hired by nursing facilities. No recommended caseload. A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A facility of 120 beds or less must employ or contract with a qualified social worker (or in lieu thereof, a social worker who is licensed by the Texas State Board of Social Work Examiners as prescribed by the Human Resources Code, Chapter 50, §50.016(a)) and who meets the requirements of subsection (b)(2) of this section) to provide social services a sufficient amount of time to meet the needs of the residents.
Coordination With Other Agencies	Interaction with other programs is limited. Once an individual enters a nursing facility, the facility becomes responsible for the individual's care. Enrollment in other state programs is typically discontinued at the time of admission to a facility. During enrollment determination, there may be limited coordination with mental health or mental retardation programs.
Case Manager Qualifications	A qualified social worker is an individual who is licensed, including a temporary or provisional license, by the Texas State Board of Social Work Examiners as prescribed by Chapter 50 of the Human Resources Code and who has at least: • A Bachelor's degree in social work or a bachelor's degree in a human services field, including, but not limited to, sociology, special education, rehabilitation counseling and psychology; and • One year of supervised social work experience in a health care setting working directly with individuals.
Program Funding Source(s)	Medicaid, Title XIX, some Medicare and some private pay.
Reimbursement Methodology	Nursing facility services are provided on a contracted basis. Unit rates for nursing facilities are per diem rates that include all services delivered in the institutional setting; therefore, there are no units or rates for social workers in nursing facilities.

Nursing Facility	
Performance Measures	None related specifically to case management.
Claims Systems/Databases	Service Authorizations are stored in the Service Authorization System database in DADS. Provider claims are processed through systems at the Texas Medicaid and Healthcare Partnership (TMHP), the state's Medicaid claims processing vendor. Once approved for payment by TMHP, claims are sent to DADS for processing through its fiscal systems and then to the State Comptroller for payment. DADS' Chief Financial Officer maintains a database for internal reporting purposes that contains both authorization and payment data. There is no system at the state that tracks information specific to case management and nursing facilities do not separately track this information.

Relocation Assistance for Individuals Transitioning from Nursing Facilities into Community Settings	
Program Description	Statewide Relocation Assistance is available to nursing facility residents from the Independent Living Centers (ILCs). DADS has contracted with four ILCs to assist in the transition of individuals from facilities to the community. The ILCs help transition residents identified in all DADS regions to community long-term support systems to enable individuals of all ages, including children, who have a disability or long-term service needs to: • Live in the most integrated community setting appropriate to their individual support requirements and their preferences. • Exercise meaningful choices about their living environment, providers and services. • Obtain quality services in a manner as consistent as possible with their community living preferences and priorities.
Service Definition	The Relocation program does not include a single service called "case management," but many of the relocation provider's activities could be considered case management-type services. The relocation process includes: • Outreach • Identification and assessment • Relocation assistance • Follow up Caseloads vary by provider. The state does not specify caseload requirements.
1915(c) Waiver Service	No.
Delivery Model	Relocation services are provided by contracted providers selected

Relocation Assistance for Individuals Transitioning from Nursing Facilities into Community Settings	
	through a competitive bidding process.
Coordination With Other Agencies	Contracted providers most commonly coordinate with regional DADS case managers and also coordinate with the STAR+PLUS and Integrated Care Management managed care programs.
Case Manager Qualifications	The state does not specify qualifications, but contractors reported this information in the responses to the RFP.
Program Funding Source(s)	General revenue only.
Reimbursement Methodology	Cost-based reimbursement.
Performance Measures	Each service provider proposes its own performance targets and reports on progress in meeting target. The state requires relocation providers to submit monthly and quarterly reports that provide detail regarding: • Assessments performed • Contacts made • Individuals relocated • Unsuccessful relocations • Individuals returned to a nursing facility • Barriers and challenges to relocation
Claims Systems/Databases	There is no claims database for the Relocation Program. The program tracks key data using an Excel spreadsheet.

Texas Home Living Program (TxHmL)	
Program Description	The Texas Home Living (TxHmL) Program provides essential services and supports so that persons with mental retardation can continue to live with their families or in their own homes in the community. TxHmL services are intended to supplement instead of replace the services and supports a person may receive from other programs, such as the Texas Health Steps Program or from natural supports such as his or her family, neighbors or community organizations. TxHmL Program services are limited to a yearly cost of $10,000 per participant. Individuals must be Medicaid-eligible to receive TxHmL services.
Service Definition	Case management is not a covered service of the TxHmL program. TxHmL recipients receive targeted case management through MRA providers. Targeted case management includes: • Services that will assist individuals who receive waiver services in gaining access to needed waiver and other state plan services. • Needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified. The average case management caseload is 40:1.
1915(c) Waiver Service	Yes.
Delivery Model	Case managers are employees of the MRAs that contract with DADS to be a provider of targeted case management services.
Coordination With Other Agencies	Service coordinators most frequently coordinate with school districts and other health and human services agencies (e.g., DSHS, DARS), as well as community resources.

Texas Home Living Program (TxHmL)	
Case Manager Qualifications	Service coordination may be provided only by an employee of an MRA. The qualifications for service coordinators are: • A bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral or human service field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education and criminal justice; or • A high school diploma or a certificate recognized by a state as the equivalent of a high school diploma and: ➢ Two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making; and ➢ Personal experience as an immediate family member of an individual with mental retardation. • The MRA, at its discretion, may require additional education and experience for staff who provide service coordination. • At the discretion of the MRA, a staff person who was authorized by an MRA to provide service coordination prior to April 1, 1999, may provide service coordination without meeting the minimum qualifications described above.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	The state pays through the performance contract with General Revenue on a quarterly basis. MRAs can submit claims for targeted case management services through TMHP on a case rate basis.

Texas Home Living Program (TxHmL)	
Performance Measures	Each MRA must meet its quarterly target for service coordination. For example, the MRA for Tarrant County is required to provide service coordination to an average of at least 680 individuals per month for each quarter. The Contract Accountability and Oversight Unit in the MRA Section of Access and Intake at DADS, conducts an annual review of each MRA. The review covers verification of service coordinators' qualifications, required training and compliance with Service Coordination rules. A report titled "Potential Lost Medicaid" is available to MRAs and lists consumers who are incorrectly identified as not eligible for Medicaid to ensure proper billing for Medicaid-covered service coordination. DADS uses the report to ensure an MRA is properly billing for Medicaid-covered service coordination.
Claims Systems/Databases	Targeted case management claims are billed through TMHP.

Appendix D.2: Case Management Program Summary: Department of Assistive and Rehabilitative Services (DARS)

Blind Children's Vocational Discovery and Development Program	
Program Description	The Blind Children's Vocational Discovery and Development Program was established to provide children who are blind and children who have visual impairments with services to supplement the services provided by other state agencies when the division determines that the provision of the services is appropriate and that the services will assist the children in achieving financial self-sufficiency and a fuller and richer life. The target population consists of children who are blind or visually impaired, birth up to 22 years of age.
Service Definition	Medicaid case management services are provided to Medicaid-enrolled individuals who are blind or have visual impairments to assist them with gaining access to medical, social, educational vocational and other appropriate services that will help these individuals reach or maintain an optimum level of functioning in the community. Case management services are: • Initial intake • Comprehensive assessment from which a plan is developed for the delivery of services • Service implementation • Monitoring and tracking of service delivery • Reassessment For case management services to be payable, there must be one or more case management contacts per month on the client's behalf or with the client, either face-to-face or by telephone, for the purpose of enabling the client to obtain services. Case management services are not payable when performed in conjunction with the proper and efficient management of the State Plan. The case manager is responsible for the overall coordination of services for the Medicaid client.

Blind Children's Vocational Discovery and Development Program	
Service Definition, *continued*	In addition to case management services, direct services are provided to consumers and their families. Examples of direct services include: • Provision of training, either individually-based or in groups • Provision of counseling and guidance services • Purchase of equipment or services • Delivery of equipment or services The average caseload must be less than 85:1. Case management services are also provided to non-Medicaid recipients.
1915(c) Waiver Service	No.
Delivery Model	• Approximately 31 full-time Blind Children's Program (BCP) specialists and two half-time specialists, totaling 32 FTEs employed by the Division for Blind Services (DBS), are responsible for providing case management services, in addition to other direct care services. • A case manager may have no more than 85 cases active at one time.
Coordination With Other Agencies	Coordinates with programs such as Early Childhood Intervention (ECI) and Independent School Districts (ISDs), Educational Service Centers (ESCs) and the Texas School for the Blind and Visually Impaired (TSBVI). Also makes referrals to Department of Aging and Disability Services (DADS) and Department of State Health Services (DSHS) mental health services and waiver programs. Specialists participate in local Community Resource Coordination Group (CRCG) meetings. Specialists also coordinate with local organizations, such as service fraternities/sororities or community service agencies.

Blind Children's Vocational Discovery and Development Program	
Case Manager Qualifications **Case Manager Qualifications, *continued***	The minimum requirements needed for a BCP specialist are: • Master's degree from an accredited college or university with an area specialization in child development, special education, psychology or a related field with one year of work experience with children with disabilities (preferably visually impaired) or their parents; or • A Bachelor's degree in a related field with a minimum of two years work experience with children with disabilities (preferably visually impaired) or their parents.
Program Funding Source(s)	State General Revenue, Medicaid, endowments, other third-party payments.
Reimbursement Methodology	The rates are determined as follows: • Total allowable costs for the provider will be determined by an analysis of the allowable historical costs for the previous year. • An average allowable monthly rate per client is calculated. • No cost settlement will be used in this system. • The reimbursement rate will be redetermined at least annually according to the Texas Administrative Code 1.15.355.J.20 Rule 355.8381. The Division for Blind Services submits financial and statistical information to the Texas Health and Human Services Commission (HHSC), excluding unallowable costs. Effective January 1, 2007, the rate is $102.78 per client month.
Performance Measures	Outcome-based performance measures: • Percent of consumers surveyed who were satisfied with

Blind Children's Vocational Discovery and Development Program	
	services. (Consumers are surveyed after case closure to determine if they are satisfied with services.) • Percent successfully completing planned services. • Average cost per child served. • Number receiving habilitative services.
Claims Systems/Databases	• Collect eligibility information. • Collect and organizing billing data. • Transmit billing. • Generate consumer bills once a month. • Maintains and update automated case management programs.

Early Childhood Intervention (ECI) Program	
Program Description	ECI is a coordinated system of services available in every Texas county for children birth to age three with disabilities or delays. ECI is federally and state funded through the Individuals with Disabilities Education Act (IDEA, P.L. 108-446). ECI supports families to help children reach their potential through developmental services. ECI contracts with local agencies and organizations through an annual funding application process. Approximately half of ECI contracts are with local mental health mental retardation facilities; about one-quarter are non-profit organizations. The staff of these organizations provide service to families. ECI staff includes physical, occupational, speech and language therapists, teachers, social workers and early intervention specialists. ECI programs must follow the ECI Policy and Procedures Manual. ECI is designated by the governor as the lead agency for children with special needs enrolled in IDEA Part C services. Federal language specifies that ECI is the single point of contact for children under three with special needs enrolled in the IDEA Part C Program.
Service Definition	The ECI program is regulated by IDEA PL 108-446 Part C federal regulations. These regulations set rules and funding requirements for state ECI programs. In order for a state to participate in the program, it must assure that early intervention will be available to every eligible child and the child's family. The current statute and regulations for IDEA Part C contain many requirements states have to meet, including specifying the minimum components of a comprehensive statewide early intervention system. One of the requirements is to provide service coordination. In the Code of Federal Regulations (34 CFR §303.23) all children and families eligible for ECI services must be provided with one service coordinator who acts as a single-point of contact within the program and community. ECI services coordinators must meet specific guidelines as outlined in 34 CFR §303.23 (d). In order for service coordination to be billed as targeted case management, the activity must meet the specific guidelines outlined in the state plan amendment and the child receiving the service must be enrolled in Medicaid. All targeted case management activities are service coordination activities, but not all service coordination activities are eligible to be billed as targeted case management to Medicaid.

Early Childhood Intervention (ECI) Program	
Service Definition, ***continued***	If targeted case management/service coordination services were provided by another entity other that the ECI program, ECI is still required to provide service coordination. The revenue received from Medicaid targeted case management would need to be replaced by General Revenue funds in order to comply with the services coordination requirements found in the federal regulations IDEA Part C. Targeted Case Management services are provided to assist eligible individuals in gaining access to needed medical, social, educational, developmental and other appropriate services. Case management services are defined as those that directly benefit eligible children. The case management service is provided to assist targeted Medicaid clients in gaining access to these other services and not to deliver the services. Case management services may be delivered either face-to face or by telephone, for the purpose of enabling the client to obtain services as specified above. The target population consists of infants and toddlers from birth to three years of age with developmental delays who are Medicaid-enrolled. Case management services include: • Intake and needs assessment. The case manager provides information concerning case management and early intervention to the client's family and assists the child and family in gaining access to the evaluation and assessment process. A needs assessment is conducted to document needs of the client such as medical, social, nutritional educational, developmental or other appropriate needs. • Plan of care. Information gathered from the comprehensive needs assessment is incorporated into an individualized family services plan of care (IFSP). With family consent, family concern, priorities and resources are identified and documented in the plan. The plan summarizes assessment results, includes the services necessary to enhance the development of the child and the capacity of the family to meet the child's unique needs and must be coordinated with other service providers involved in delivery of early intervention services.

Early Childhood Intervention (ECI) Program	
Service Definition, ***continued***	• Service coordination and monitoring. The case manager ensures the recipient's access to the care, resources and services to meet the client's needs. The case manager assists the family in taking responsibility for ensuring that services are delivered and works with medical providers, ECI staff and other community resources to coordinate care and to monitor and follow up on the implementation, effectiveness and appropriateness of the child's plan of care and services. • Reassessment and Transition Planning: A reassessment of the client's progress and needs is conducted at least every six months. At reassessment the case manager will determine if modifications to the service plan are necessary and if the level of involvement by the case manager should be adjusted. When services are no longer needed or the child no longer qualifies for services, the case manager facilitates the planning, coordination, advocacy and transition to other appropriate care. The goal is to have at least one service coordination contact per month. Contractors receive a contract to provide services to a fixed number of children. The average caseload information is not available.
1915(c) Waiver Service	No.
Delivery Model	ECI Targeted Case Management services, along with all other ECI services, are provided through 58 contractors. The host agencies of the ECI contracts are Independent School Districts (ISDs), Mental Health and Mental Retardation centers, and private, non-profit agencies. ECI staff provide ECI services in the child's natural environments (home, child care setting, neighborhood or community setting). ECI targeted case management services are provided by phone or in person to assist the child's family in accessing needed services.

Early Childhood Intervention (ECI) Program	
Coordination With Other Agencies	Memoranda of Understanding with DSHS programs which include Children with Special Health Care Needs (CSHCN) Services Program and Case Management Services for Children and Pregnant Women (CPW), Head Start, and the Texas Education Agency regarding Auditory and/or Visual impairments.
Case Manager Qualifications	Targeted Case Management for the ECI program can be provided only by.professionals or paraprofessionals employed by the ECI program. The staff must complete the ECI Family-Centered Service Coordination Module to provide service coordination services. Programs must maintain file documentation verifying completion of the service coordination module.
Program Funding Source(s)	Targeted Case Management services are funded by Medicaid. Other ECI services are funded by: state general revenue, federal funds from the Individuals with Disabilities Education Act Parts B and C, Foundation School Fund, TANF, private insurance, CHIP, family cost share, and Medicaid funds.
Reimbursement Methodology	ECI contractors performing Targeted Case Management bill directly to Texas Medicaid and Healthcare Partnership (TMHP) for services. Contractors are reimbursed on a monthly fee basis. The rate is currently $141.83. According to Texas Administrative Code, Rule 355.9007, ECI staff develops proposed reimbursement rates and recommends them to the Health and Human Services Commission. The recommended rate is determined in the following manner: • Each provider's total reported costs on the Time and Financial Information (TAFI) report are compared with their total reported costs in the ECI financial report. • Providers are eliminated whose variance between reported costs on the TAFI and the ECI financial reports exceeds plus or minus two standard deviations of the mean provider variance. • Total allowable case management costs for each provider will be determined from the allowable historical costs reported on the TAFI report.

Early Childhood Intervention (ECI) Program	
Reimbursement Methodology, ***continued***	• Each provider's total allowable case management cost is projected from the historical cost reporting period to the prospective reimbursement period using inflation factors. • Each provider's total allowable case management cost is divided by their associated number of unduplicated case management contacts for the period, thus determining the providers cost per contact. Unduplicated case management contacts are defined as case management contacts which are delivered to eligible children and which are counted only once for each child during a specific month. • The mean provider cost per contact is calculated and the statistical outliers are eliminated. After removal of the statistical outliers, the mean cost per contact is calculated. • The mean cost per contact is the proposed reimbursement rate.
Performance Measures	Measures from DARS/ECI contract with ECI providers include: Outcomes measures: • Acceptance of comprehensive services Output measures: • Comprehensive services enrollment • Reporting timelines • Medicaid Targeted Case Management Collections Individualized Family Service Plan (IFSP): • IFSP meetings within 45 days
Claims Systems/Databases	The claims system for targeted case management is TMHP.

Vocational Rehabilitation Program	
Program Description	The Vocational Rehabilitation (VR) Program helps people who have physical or mental disabilities prepare for, find or keep employment. Gaining skills needed for a career, learning how to prepare for a job interview or getting the accommodations needed to stay employed are just a few of the ways this program helps people with disabilities increase productivity and independence. The counselor and consumer work together to: • Decide on an employment goal. • Develop a program of vocational rehabilitation services to achieve the goal. The program is not an entitlement and is only provided to individuals meeting eligibility criteria
Service Definition	After an individual is determined eligible, the vocational rehabilitation counselor works with the individual to develop a plan for employment. They provide services required to assist the person in returning to work and are required to allow consumer choice. The average caseload information is not available.
1915(c) Waiver Service	No.
Delivery Model	Agency staff, as required by law, employed by Division of Rehabilitation Services (DRS) or Division for Blind Service (DBS). They either directly provide, contract for or arrange for services. Recommend meeting with consumer at least once every 30 days.
Coordination With Other Agencies	Memos of Understanding with DSHS, CSHCN and CPW. Vocational Rehabilitation counselors are knowledgeable about resources in the community.

Vocational Rehabilitation Program	
Case Manager Qualifications	Master's degree in vocational rehabilitation or closely related field; must meet certified rehabilitation counselor national standards; there are some bachelor's level individuals providing services.
Program Funding Source(s)	United States Department of Education (80 percent), State (20 percent).
Reimbursement Methodology	The U.S. Department of Education grant is capped. The VR grant is used to pay for a variety of expenses, including salaries, purchased services and other reporting costs. The Department of Education does not require DARS to break down salaries by function or in any other manner. The Department of Education has strict regulations on the performance of the VR program and the manner in which DARS recovers administrative costs. The Division does not separately identify the cost of case management services.
Performance Measures	Extensive Quality Assurance and Improvement Plan. Use surveys to determine consumer satisfaction.
Claims Systems/Databases	The DBS and DRS Vocational Rehabilitation programs do not separately track case management expenditures or utilization but the programs do use a data base to manage case management information. Each program uses a different case management database system.

Appendix D.3: Case Management Program Summary: Department of Family and Protective Services (DFPS)

Adult Protective Services Case Management	
Program Description	The Department of Family and Protective Services (DFPS) Adult Protective Services (APS) program is responsible for investigating abuse, neglect and exploitation of adults who are elderly or have disabilities. • In-home APS serves persons who are aged 65 or older or, if age 18-64, have a disability and reside in the community (e.g., private homes, adult foster homes, unlicensed board and care homes, etc.). • APS is responsible for investigating abuse, neglect and exploitation of clients receiving services in mental health or mental retardation state-operated and/or contracted settings that serve adults and children with mental illness or mental retardation including: state schools; state hospitals; state centers; community mental health/mental retardation centers; and community center contractors; and HCS and TxHmL Waiver programs. • Individuals eligible for Texas DFPS targeted case management program are Medicaid recipients receiving foster care, child protective services, adoption assistance or adult protective services.
Service Definition	Targeted case management services provided through the APS program assist the target population in gaining access to needed medical, social, educational and other services. These services include services covered under the Texas Medicaid State Plan, as well as other services not provided under the Texas Medicaid State Plan. Case management services include: • Assessment • Case Planning • Service Coordination and Monitoring • Case Plan Reassessment

Adult Protective Services Case Management	
Service Definition, *continued*	Case workers oversee the provision of emergency protective services for a short time to stabilize the person. Long-term case management is provided by other programs. The caseload as of March 2007 was 7:1 for facility investigators; 44:1 for in-home investigators.
1915(c) Waiver Service	No.
Delivery Model	APS Case Workers, who are employees of DFPS, provide case management services under the APS program.
Coordination With Other Agencies	APS coordinates with DADS, DSHS, local Mental Health and Mental Retardation Authorities as well as their contractors. APS refers clients to local community organizations that provide services to the elderly or adults with disabilities.
Case Manager Qualifications	All DFPS APS Case Workers are required to have a bachelor's degree, preferably related to the fields of social work, gerontology, developmental disabilities, aging or psychology.
Program Funding Source(s)	State General Revenue, Medicaid, Social Services Block Grants.
Reimbursement Methodology	The program claims Medicaid reimbursement for targeted case management for individuals receiving services from the DFPS APS program.
Performance Measures	There are no performance measures that are specifically related to case management. The performance measures that APS annually reports to the Legislative Budget Board measure program outputs and efficiencies related to the delivery of protective services. These measures are: • Percent of adults found to be abused/neglected/exploited who are served

Adult Protective Services Case Management	
	• Average number of APS cases open for protective services • Average monthly cost per APS case open for protective services
Claims Systems/Databases	IMPACT system captures encounter data.

Child Protective Services Case Management	
Program Description	Child Protective Services (CPS) covers children up to age 19 who have been a victim or are at risk of abuse, neglect and exploitation. Services provided include intake, investigations, risk assessment and other such services. Individuals eligible for Texas DFPS targeted case management program are Medicaid recipients receiving family based safety services, foster care services and adoption assistance.
Service Definition	Targeted case management services are services which will assist the target population in gaining access to needed medical, social, educational and other services. These services include services covered under the Texas Medicaid State Plan, as well as other services not provided under the Texas Medicaid State Plan. Case management services include: • Assessment • Case Planning • Service Coordination and Monitoring • Case Plan Reassessment Services must be available 24 hours a day, seven days a week, 365 days a year. Case workers receive consultative support from direct line supervisors. The average caseload information is not available.
1915(c) Waiver Service	No.
Delivery Model	CPS Case Workers, who are employees of DFPS, provide case management services under the CPS program. DFPS contracts out for some family-based services which are not reimbursed by Medicaid.
Coordination With Other Agencies	CPS coordinates with DADS, DSHS, HHSC, local Mental Health Authorities and Mental Retardation Authorities as well as their contractors.

Child Protective Services Case Management	
Case Manager Qualifications	All CPS case workers are required to have a Bachelor's degree in a related field. Completion of a two year certification program is not required but is directly tied to upgrades. In addition, case workers must complete 12 weeks of classroom and on-the-job training prior to being assigned cases.
Program Funding Source(s)	State General Revenue, Medicaid, IV.B subparts 1 and 2, IVE Foster Care and Adoption Assistance, TANF.
Reimbursement Methodology	The program claims Medicaid reimbursement for targeted case management for individuals receiving services from the DFPS CPS program.
Performance Measures	Seven outcomes are evaluated: • Safety 1 – Children are first and foremost protected from abuse and neglect. • Safety 2 – Children are safely maintained in their homes whenever possible and appropriate. • Permanency 1 – Children have permanency and stability in their living situations. • Permanency 2 – The continuity of family relationships and connections is preserved for children. • Well Being 1 – Families have an enhanced capacity to provide for their children's needs. • Well Being 2 – Children receive appropriate services to meet their educational needs. • Well Being 3 – Children receive adequate services to meet their physical and mental health needs.
Claims Systems/Databases	IMPACT system captures encounter data

Appendix D.4: Case Management Program Summary: Department of State Health Services (DSHS)

Adult Mental Health Case Management	
Program Description	Adult mental health case management services assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs.
Service Definition	Targeted case management. For adults, case management services are routine (PRN, as needed). • Mental Health Case Management services assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine Mental Health Case Management for an adult is primarily site-based. Reimbursable case management activities may include: ➢ Assisting the individual in identifying the individual's immediate need. ➢ Assisting the individual in gaining access to the community resource that may address that need. ➢ If notified that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis. • Related, non-billable "indirect" activities that are included in the rate may include: ➢ Documentation of the above activities ➢ Case management staff meetings ➢ No shows/messages ➢ Telephone contacts ➢ Contacts with collaterals ➢ Administration of the uniform assessment
Service Definition,	The average caseload information is not available.

Adult Mental Health Case Management	
continued	
1915(c) Waiver Service	No.
Delivery model	Adult mental health case management services are provided through 37 local Community Mental Health and Mental Retardation Centers throughout the state.
Coordination With Other Agencies	Overlaps may occur in high-needs individuals who require services from many different agencies. Community Resource Coordination Groups for Adults (CRCGAs) develop service plans for individuals whose needs can be met only through inter-agency coordination and cooperation.
Case Manager Qualifications	Qualification requirements for individuals providing adult mental health case management services are: • An employee of a local Community Mental Health and Mental Retardation Center. • Bachelor's degree with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology early childhood education, early childhood intervention; or • Registered nurse; or • Graduation from an accredited high school or equivalent, plus three continuous years of full-time experience in the provision of MH case management services as of August 31, 2004. Staff meeting these requirements may perform and submit claims for all three case management activities. Individuals without a bachelor's or RN degree cannot administer the uniform assessment.
Program Funding	Medicaid. State General Revenue for non-Medicaid consumers.

Adult Mental Health Case Management	
Source(s)	
Reimbursement Methodology	An adult mental health case management Medicaid reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact at the current rate of $16.21 per unit. For Medicaid reimbursable contacts, contract providers submit claims for only the federal share of the claim. The state share of the reimbursement is covered through the contractor's grant with the state.
Performance Measures	There are no measures specific to case management as case management is one service within a service package.
Claims Systems/Databases	WebCARE database/encounter data. RDM Translator

Children's Mental Health Case Management	
Program Description	Children's mental health case management services assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs and are classified as either "routine" or "intensive."
Service Definition	Targeted case management. Children's mental health case management services assist an individual in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine mental health case management for children and adolescents is primarily site-based (versus community based). Intensive case management for children and adolescents is primarily community-based and has a high frequency of contact. Case management activities may include: For routine case management: • Assisting the individual in identifying the individual's immediate need. • Assisting the individual in gaining access to the community resource that may address that need. • If notified that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis. For intensive case management: • Gather information about the individual's strengths and service needs across life domains. • Utilize wraparound process planning to develop a mental health case management plan that addresses the individual's unmet needs across life domains. • Assist the individual in gaining access to the needed services and service providers. • Monitor the individual's progress toward the outcomes set forth. in the mental health case management plan. • If notified that the individual is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis. Related, non-billable "indirect" activities that are included in the rate

Children's Mental Health Case Management	
Service Definition, *continued*	may include, but are not limited to: • Documentation of the above activities • Case management staff meetings • No shows/messages • Telephone contacts • Contacts with collaterals • Administration of the uniform assessment • Staff travel Two types of case management: 1. Routine – for lower intensity cases 2. Intensive – for high need children using evidence-based practices and serving as a wrap-around The average caseload information is not available.
1915(c) Waiver Service	No.
Delivery Model	Child mental health case management services are provided through 37 local Community Mental Health and Mental Retardation Centers throughout the state.
Coordination With Other Agencies **Coordination With Other Agencies,** *continued*	Overlaps may occur in high-needs individuals who require services from many different agencies. Community Resource Coordination Groups (CRCGs) coordinate service plans for individuals and families whose needs can be met only thru inter-agency coordination and cooperation.

Children's Mental Health Case Management	
Case Manager Qualifications	Qualification requirements for individuals providing child mental health case management services include: • Bachelor's degree with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology early childhood education or early childhood intervention; or • Registered nurse; or • Graduation from an accredited high school or equivalent, plus three continuous years of full-time experience in the provision of MH case management services as of August 31, 2004. Staff meeting these requirements may perform and submit claims for all three case management activities. Individuals without a Bachelor's or RN degree cannot administer the uniform assessment.
Program Funding Source(s)	Medicaid. State general revenue for non-Medicaid consumers.
Reimbursement Methodology	A child mental health case management Medicaid reimbursable contact is the provision of a case management activity by an authorized case manager during a face-to-face meeting with an individual authorized to receive that specific type of case management. A billable unit of case management is 15 continuous minutes of contact at the current rate $19.61 per unit for routine case management and $31.33 per unit of intensive case management. For Medicaid reimbursable contacts, contract providers submit claims for only the federal share of the claim. The state share of the reimbursement is covered through the contractor's grant with the state.
Performance Measures	There are no measures specific to case management as case management is one service within a service package.
Claims	Providers submit claims for children's mental health case management

Children's Mental Health Case Management	
Systems/Databases	services directly to TMHP. Client information is stored and maintained with the CARE and WebCARE systems: • CARE is the mainframe-based central client database and application for mental health and mental retardation services used by DADS and DSHS. • WebCARE is a web-based application that duplicates and supplements some functions of CARE. The primary purpose of WebCare is to support the Texas Recommended Assessment Guidelines (TRAG) for adult and youth mental health services.

Case Management Services for Children and Pregnant Women (CPW)	
Program Description	Case Management for Children and Pregnant Women (CPW) provides services to children who are eligible for Medicaid with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, to encourage the use of cost-effective health and health-related care. Together, the case manager and family assess the medical, social, educational and other medically necessary service needs of the eligible recipients. Provided under Medicaid Texas Health Steps (THSteps) Early and Periodic Screening Diagnosis and Treatment program.
Service Definition	Case management services are provided to assist eligible recipients in gaining access to medically necessary medical, social, educational and other services to: • Encourage the use of cost-effective health and health-related care • Make referrals to appropriate community resources • Discourage overutilization or duplication of services • Reduce morbidity and mortality Services Include: • Intake/eligibility determination • Needs assessment • Service plan • Follow-up visits • Locating community resources • Advocacy on behalf of clients • Problem solving with clients and families • Empowering clients to be able to access services on their own in the future
Service Definition,	Case management for children and pregnant women is not a "gatekeeper"

Case Management Services for Children and Pregnant Women (CPW)	
continued	function. The following are considered "billable" contacts according to Title 25, Part 1, Rule 27.5 of the Texas Administrative Code: • Comprehensive Visit – A face-to-face visit that includes the development of a Family Needs Assessment and the development of a service plan. • Follow-up Contact – A face-to-face or telephone contact with the eligible recipient and his/her family during which the case manager and the client/family review and reassess the client/family's needs, determine what referrals and services specified in the Service Plan have been received by the client/family and develop appropriate modifications to the Service Plan.
1915(c) Waiver Service	No.
Delivery Model	CPW case management is provided through regional staff employed by DSHS (who also provide CSHCN Services Program case management) and through enrolled Medicaid providers who are approved by DSHS and enrolled with TMHP. Medicaid providers include: • Individual social workers and nurses • Groups of case managers providing case management services only • Agencies that provide multiple services including case management Approximately half of the case management providers in the CPW program are individual social workers or nurses. The other half of the providers are agencies including counseling agencies, home health providers, physician offices, local and state health departments and school districts (through school nurses, teen parenting programs and school-based clinics).

Case Management Services for Children and Pregnant Women (CPW)	
Coordination With Other Agencies	Coordinate with ECI – "Keep the Ball Rolling" training to ensure providers are aware of resources and to make sure that children continue to receive services when they no longer qualify for ECI. ECI is mandated by Federal legislation to provide service coordination to ECI eligible children. DFPS case workers refer children to either enrolled CPW providers or to DSHS regional staff when children are transitioning out of DFPS services or when children are in foster care and have complex medical needs. Staff from DFPS and DSHS meet on a regular basis throughout the state to staff client cases, coordinate services and ensure awareness of Medicaid services available for 0-21 year olds.
Case Manager Qualifications	A CPW case manager must be a currently licensed Registered Nurse (with a diploma, an associate's, Bachelor's or advanced degree) or a currently licensed Social Worker (with a Bachelor's or advanced degree). Additionally, case managers must posses: • Two years of cumulative, paid, full-time work experience in the past ten years; or • Two years of supervised, full-time educational internship/practicum experience in the past ten years Experience can be a combination of paid full-time work and supervised educational internship/practicum. Additionally, experience must include working with children, up to age 21 and/or pregnant women and must include assessing the psychosocial and health needs and making community referrals. The majority of case managers employed by DSHS are social workers.
Program Funding Source(s)	Medicaid.
Reimbursement Methodology	• CPW case management services provided through enrolled Medicaid providers are reimbursed on a fee-for-service basis at a rate of $54.58 for face-to-face contacts and $18.00 for telephone contacts. The fees for CPW were based on the fees for a former program and have not been adjusted since 1991. The rates do not include collateral contacts

Case Management Services for Children and Pregnant Women (CPW)	
Reimbursement Methodology, ***continued***	between billable visits. • Salaries for DSHS regional staff providing case management to Medicaid eligible clients are paid through Medicaid administrative funds. • About one-half of CPW services are provided by private providers (Medicaid fee-for-service) and the other half are provided by DSHS regional staff (Medicaid administrative funding).
Performance Measures	• Maintains a complaint log. • Conducted on statewide client satisfaction survey. Clients reported a high level of satisfaction with services. • Enrolled CPW providers are required to conduct satisfaction surveys with clients. • DSHS central office conducts quarterly utilization review (UR) activities that include review of client records when indicated. The UR process includes an analysis of the following outliers: ➢ Outlier 1. One case manager exceeding seven paid claims on one date of service for more than 10 percent of the days in the quarter. ➢ Outlier 2. Case manager with average of seven or fewer days between dates of service for all paid follow-up claims for more than 10 percent of the clients with approved requests and paid claims during the quarter. ➢ Outlier 3. More than 10 days between date authorization returned and date of service on paid claim for comprehensive visit for more than 10 percent of the clients reviewed for each case manager. ➢ Outlier 4. More than three family groups with three or more family members (same case name) followed by one case manager. ➢ Outlier 5. More than 5 percent of recipients for a provider (individual or agency) with an approved request during the

Case Management Services for Children and Pregnant Women (CPW)	
Performance Measures, *continued*	quarter reviewed that have no claims.
Claims Systems/Databases	Have a database for tracking and processing prior authorizations for the program. Maintain a database of Medicaid enrolled providers. TMHP is used by enrolled providers for claims processing. An automated DSHS centralized system for recording encounter data by DSHS case managers is being developed. Currently, each region maintains their data and reports quarterly.

Case Management Services for Children with Special Health Care Needs	
Program Description	The Children with Special Health Care Needs (CSHCN) Services Program provides services to children with extraordinary medical needs, disabilities and chronic health conditions. The CSHCN Services Program's health care benefits include payments for medical care, family support services and related services not covered by Medicaid, CHIP, private insurance or other third-party payers. Provides services to children up to 21 years of age. The CSHCN Services Program Rules state that "[t]he CSHCN Services Program may provide and/or reimburse for case management services to persons in need of such services who are bona fide residents [of Texas] and who are determined not to have another primary provider and/or funding source for such services. The program's case management services are focused on individuals (and their families) who are eligible, seeking eligibility or potentially seeking eligibility for the program's health care benefits (includes clients who are on the waiting list for health care benefits). However, the program may offer and provide case management services to individuals (and their families) who are neither eligible nor seeking eligibility for the program's health care benefits… Case management services may be made available to program clients through public health regional offices or other resources to assist clients and their families in obtaining adequate and appropriate services to meet the client's health and related services needs."
Service Definition	CSHCN Service Program case management services include: • Planning, accessing and coordinating needed health care and related services for children with special health care needs and their families. Case management services are performed in partnership with the child, the child's family, providers and others involved in the care of the child and are performed as needed to help improve the well-being of the child and the child's family. • Counseling for the child and the child's family about measures to prevent the transmission of AIDS or HIV and the availability in the geographic area of any appropriate health care services such as mental health care,

Case Management Services for Children with Special Health Care Needs	
Service Definition, ***continued***	psychological care and social and support services. As stated in the CSHCN Services Program FY06 Competitive RFP for case management services, "[t]he purpose of case management is to help access and coordinate the use of services and resources for children with special healthcare needs and their families. Expectations of funded case management projects will include, but are not limited to, the following: • To provide a single point of access to services for comprehensive care and support which draw upon community resources for the provision of those services. • To develop an individual plan of service within the context of the family through the process of individual assessment and goal setting in partnership with the child/youth with special health care needs and the child's family (or adult with cystic fibrosis). • To assist the individual in the achievement of his/her full potential, whatever that may be. • To support the family in assuming primary responsibility for the child's case management. • To link the child with an appropriate medical home to ensure comprehensive, coordinated and high quality medical care. • To act as liaison between the individual/family and the providers of services, when necessary. • To recognize and support the right of each individual to take control of his or her destiny.

Case Management Services for Children with Special Health Care Needs	
1915(c) Waiver Service	No.
Delivery model	CSHCN case management is provided either through DSHS Regional Staff or 13 contractors. DSHS issues RFPs to contract for services.
Coordination With Other Agencies	• CSHCN Services Program case management funds are used for case management for children with special health care needs where other appropriate funding resources are not available to the child and family. Children eligible for case management through Medicaid waiver services such as Community Living Assistance and Support Services (CLASS), Early Childhood Intervention (ECI) or other state programs should be served with those funding resources. • The CSHCN Services Program coordinates quarterly, monthly, weekly or as needed with multiple state programs and interagency groups including DARS IDEA Community Support, the ECI advisory committee, the Community Resource Coordination Group (CRCG) and the Texas Integrated Funding Initiative (TIFI).
Case Manager Qualifications	Minimum qualifications for Contractor staff providing CSHCN case management services are: • Licensed Master Social Worker with a Master's degree in Social Work and one year of experience in case management services within community programs serving CSHCN. • Licensed Baccalaureate Social Worker (LBSW) and two years of experience in case management services within community programs serving CSHCN. • Registered Nurse with a Master's degree in nursing and one year of experience in case management services within community programs serving CSHCN. • Registered Nurse with a Bachelor's degree in nursing and two years of experience in case management services within

Case Management Services for Children with Special Health Care Needs	
Case Manager Qualifications, *continued*	community programs serving CSHCN. • Family members of a CSHCN with successful and extensive experience serving as the child's case manager. • Other qualified individuals with extensive and successful experience working in community programs serving CSHCN with appropriate qualifications.
Program Funding Source(s)	CSHCN Services Program case management is funded through a Title V Block Grant from the Federal government for maternal and child health programs and through State General Revenue funds.
Reimbursement Methodology	CSHCN Services Program case management provided by contractors is reimbursed through contracts with each provider.
Performance Measures	Family/Professional Partnership And Family Satisfaction: • Families of children with special health care needs will partner in decision making at all levels and will be satisfied with the services they receive. Medical Home: • Children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home. Access to adequate health insurance/financing: • Families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need. Organization Of Community Services For Easy Use By Families: • Services for children with special health care needs and their families will be organized in ways that families can use them easily.

Case Management Services for Children with Special Health Care Needs	
Performance Measures, ***continued***	Transition To Adult Health Care, Work And Independence: • Youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work and independence. Family/Community Support: • All children with special health care needs live in families in communities, not in institutions, consistent with permanency planning principles. Quarterly report formats include: • Number of clients provided case management services by activity and level of intensity • Service encounters or contacts • Narrative regarding goals, objectives, project activities and evaluation activities • Family satisfaction • Technical assistance requests • Documentation of stakeholder meetings
Claims Systems/Databases	The CSHCN Services Program monitors the monthly vouchers that contractors submit for payment of their services and the monthly Financial Summary Reports that are submitted quarterly. In addition, the program tracks vouchers, which come through the CSHCN Services Program office for approval and uses an Excel spreadsheet to track the amount approved and the balance of funds. The claims processing unit at DSHS provides an expenditures spreadsheet. Contractors submit quarterly reports that monitor activities in relation to goals the contractors have set for themselves. The program also looks at this quarterly report as a source of data for Title V performance measure monitoring.

Appendix E: HHSC Programs that Provide Targeted Case Management

Dept.	Program	Age Group	Population	Case Management Provider	Reimbursement
DADS	Texas Home Living (TxMhL)[18]	All ages	Persons who have mental retardation or a related condition and an IQ of 75 or below.	MRA staff	$174.26 per month
DADS	Mental Retardation Authority (MRA)	All ages	Mental retardation priority population.	MRA staff	$174.26 per month
DARS	Early Childhood Intervention (ECI)	Children under age three	Individuals with visual impairment or auditory impairment, and/or a medically diagnosed physical or mental condition that has a high probability of resulting in developmental delay, a documented developmental delay or atypical development	Contracted providers, such as ISDs, Community Mental Health Mental Retardation Centers and private non-profit agencies	$141.83 per unit
DARS	Blind Children's Vocational Discovery and Development Program	Children and adolescents under age 16	Children under 16 who have blindness or visual impairments	DBS staff	$59.81 per contact
DFPS	Adult Protective	Adults age 65 or older	In-home APS serves persons who reside in the	State staff	$497.33 to

[18] Targeted case management is not provided through the TxHmL program; MRAs provide case management services to individuals who are in TxHmL.

Appendix E: HHSC Programs that Provide Targeted Case Management

Dept.	Program	Age Group	Population	Case Management Provider	Reimbursement
	Services	or ages 18-65, with a disability	community and Facility APS is responsible for clients receiving services in state-operated and/or contracted settings that serve adults and children with mental illness or mental retardation		$678.28 per unit[19]
DFPS	Child Protective Services	Children age 18 and under	Children at risk of abuse, neglect and exploitation	State staff	$497.33 to $678.28 per unit[20]
DSHS	Children's Mental Health Case Management	Children	Children with a serious emotional disturbance	Local Community Mental Health Mental Retardation Centers	Routine - $19.61 per 15 minute unit of service Intensive - $31.33 per 15 minute unit of service
DSHS	Adult Mental Health Case Management	Adults	Adults with severe and persistent mental illness	Local Community Mental Health Mental Retardation Centers	$16.21 per 15 minute unit of service

[19] Indicates range of unit cost rate per quarter for Federal Fiscal Year 2006.

[20] Indicates range of unit cost rate per quarter for Federal Fiscal Year 2006.

Appendix F: Programs that Serve All Age Groups

As displayed below, there are seven DADS programs that serve individuals of any age who have mental retardation or a condition related to mental retardation. Of these seven programs, four are waiver programs and two provide services through targeted case management. Of the case management providers for DADS programs that serve all age groups, two are Mental Retardation Authorities (MRAs) and three are contracted providers. MRAs, State staff, contracted providers and ICF/MRs provide case management services in programs that serve all age groups.

No.	Dept.	Program	Age Group	Population	Case Management Provider				Waiver Y/N	TCM Y/N	Client to Staff Ratio[21]
					MRA	Contracted Provider	State Staff	ICF/ MR			
1.	DADS	Aging and Disability Resource Centers	All ages	Adults age 60 or older or all ages with a physical disability, mental retardation or developmental disability		X			N	N	Varies by Provider
2.	DADS	Home and Community Based Services (HCS)	All ages	Persons who have mental retardation or a condition related to mental retardation.		X			Y	N	No more than 30:1
3.	DADS	Intermediate Care Facility for the Mentally Retarded (ICF/MR)	All ages	Persons who have mental retardation or a condition related to mental retardation.				X	N	N	Varies by facility
4.	DADS	Texas Home Living (TxHmL)[22]	All ages	Persons who have mental retardation or a condition related to mental retardation.	X				Y	Y	40:1

[21] Client to staff ratio is approximate as of a point in time.

Appendix F: Programs that Serve All Age Groups

No.	Dept.	Program	Age Group	Population	Case Management Provider				Waiver Y/N	TCM Y/N	Client to Staff Ratio[21]
					MRA	Contracted Provider	State Staff	ICF/ MR			
5.	DADS	Mental Retardation Authority (MRA) [23]	All ages	Mental retardation priority population	X				N	Y	40:1
6.	DADS	Consolidated Waiver Programs	All ages	Pilot waiver serving consumers who have been on the interest list for CBA, CLASS, MDCP, HCS and DBMD waivers			X		Y	N	48-49:1
7.	DADS	Community Living Assistance and Support Services (CLASS)	All ages	Persons who have mental retardation or a condition related to mental retardation		X			Y	N	30:1

[22] Targeted case management is not provided through the TxHmL program; MRAs provide case management services to individuals who are enrolled in TxHmL.

[23] Targeted case management is not provided through the TxHmL program; MRAs provide case management services to individuals who are enrolled in TxHmL.

Appendix G: Programs that Serve Children

As displayed below, the seven HHSC programs that serve children. These programs serve children with mental and physical disabilities or who have significant health needs. State staff provides case management services for five of the seven programs. Four of the programs are provided through targeted case management and one is a waiver program. DADS, DARS, DFPS and DSHS staff, some contracted provider, Medicaid providers and MRAs provide case management services in programs that serve only children.

No.	Dept.	Program	Age Group	Population	Case Management Provider		Waiver Y/N	TCM Y/N	Client to Staff Ratio[24]
					Contracted Provider	State Staff			
1.	DADS	Medically Dependant Children's Program	Children under age 21	Children who are medically dependent and qualify for nursing facility services		X	Y	N	41:1
2.	DARS	The Blind Children's Vocational Discovery and Development Program (BCVDDP)	Children under age 22	Children who have blindness or visual impairments		X	N	Y	Less than 85:1

[24] Client to staff ratio is approximate as of a point in time.

Appendix G: Programs that Serve Children

No.	Dept.	Program	Age Group	Population	Case Management Provider		Waiver Y/N	TCM Y/N	Client to Staff Ratio[24]
					Contracted Provider	State Staff			
3.	DARS	Early Childhood Intervention (ECI)	Children under age three	Children who have a visual impairment or auditory impairment, and/or a medically diagnosed physical or mental condition that has a high probability of resulting in developmental delay, a documented developmental delay or atypical development	X		N	Y	TBD
4.	DFPS	Child Protective Services	Children age 18 and under	Children at risk of abuse, neglect and exploitation		X	N	Y	TBD
5.	DSHS	Case Management for Children and Pregnant Women	Children birth through age 20; high-risk pregnant women of all ages	Children who are eligible for Medicaid with a health condition/health risk	Medicaid Provider	X	N	N	TBD
6.	DSHS	Children with Special Health Care Needs	Children up to age 21	Children with extraordinary medical needs, disabilities and chronic health conditions	X		N	N	Varies; no mandated case load
7.	DSHS	Children's Mental Health Case Management	Children age three to 18	Children with a serious emotional disturbance			N	Y	TBD

Appendix H: Programs that Serve Adults Ages 18-21 and Older

Of the nine programs listed below that serve adults between the ages of 18 and 60, four provide case management services through contracted providers and five deliver case management through State staff. Two are waiver programs and two programs provide services through targeted case management.

No.	Dept.	Program	Age Group	Population	Case Management Provider			Waiver Y/N	TCM Y/N	Client to Staff Ratio[25]
					Contracted Provider	State Staff	Nursing Facility			
1.	DADS	Community Based Alternatives (CBA)	Adults age 21 and older	Persons who would qualify for nursing facility services		X		Y	N	200-300:1
2.	DADS	Community Care for the Aged and Disabled (CCAD)	Adults age 18 and older	Individuals who are aged or have disabilities who are not self-sufficient, and who might otherwise be subject to unnecessary institutionalization		X		N	N	200-300:1
3.	DADS	Deaf/Blind Multiple Disabilities (DBMD)	Adults age 18 and older	Individuals with deafness, blindness and at least one	X			Y	N	Not available

[25] Client to staff ratio is approximate as of a point in time.

Appendix H: Programs that Serve Adults Ages 18-21 and Older

No.	Dept.	Program	Age Group	Population	Case Management Provider			Waiver Y/N	TCM Y/N	Client to Staff Ratio[25]
					Contracted Provider	State Staff	Nursing Facility			
				other disability						
4.	DADS	Nursing Facility	Adults	Nursing facility residents			X	N	N	Varies by facility
5.	DADS	Relocation	Adults	Individuals transitioning from nursing facility to community services	X			N	N	Varies by provider
6.	DADS	Guardianship	Adults 18 and older who have disabilities and/ or are aged and are adjudicated incapacitated by a court of law.	Adults who are incapacitated as defined by the Texas Probate Code as "An adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter to himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs."	X	X		N	N	15:1

Appendix H: Programs that Serve Adults Ages 18-21 and Older

No.	Dept.	Program	Age Group	Population	Case Management Provider			Waiver Y/N	TCM Y/N	Client to Staff Ratio[25]
					Contracted Provider	State Staff	Nursing Facility			
7.	DARS	Vocational Rehabilitation	Adults	Individuals with physical or mental disabilities		X		N	N	TBD
8.	DSHS	Adult Mental Health Case Management	Adults	Adults with severe and persistent mental illness	X			N	Y	TBD
9.	DFPS	Adult Protective Services	Adults 18 and older who have disabilities and/ or are aged	In-home APS serves persons who reside in the community and Facility APS is responsible for investigating abuse, neglect and exploitation of clients receiving services in state-operated and/or contracted settings that serve adults and children with mental illness or mental retardation		X		N	Y	7:1 for facility; 44:1 for in-home

Texas Optimization of Case Management
Analysis of Current Case Management System

The programs listed below serve adults age 60 and older and adults with disabilities. One program provides services through targeted case management. DADS and DFPS staff, contracted providers and AAA staff provide case management services in programs that serve adults age 60 and older and adults with disabilities.

No.	Dept.	Program	Age Group	Population	Case Management Provider			Waiver Y/N	TCM Y/N	Client to Staff Ratio[26]
					Contracted Provider	State Staff	AAA			
	DADS	Guardianship	Adults 18 and older who have disabilities and/ or are aged and are adjudicated incapacitated by a court of law.	Adults who are incapacitated as defined by the Texas Probate Code as "An adult individual who, because of a physical or mental condition, is substantially unable to provide food, clothing, or shelter to himself or herself, to care for the individual's own physical health, or to manage the individual's own financial affairs."	X	X		N	N	15:1
	DADS	Area Agencies on Aging (AAA)	Adults age 60 years and over	Helping people maintain their health, personal independence, dignity and ability to contribute to society			X	N	N	90:1

[26] Client to staff ratio is approximate as of a point in time.

No.	Dept.	Program	Age Group	Population	Case Management Provider			Waiver Y/N	TCM Y/N	Client to Staff Ratio[26]
					Contracted Provider	State Staff	AAA			
	DFPS	Adult Protective Services	Adults 18 and older who have disabilities and/ or are aged.	In-home APS serves persons who reside in the community and Facility APS is responsible for investigating abuse, neglect and exploitation of clients receiving services in state-operated and/or contracted settings that serve adults and children with mental illness or mental retardation		X		N	Y	7:1 for facility; 44:1 for in-home