Texas Health and Human Services Commission

Case Management Optimization

BEST PRACTICES AND EMERGING TRENDS IN CASE MANAGEMENT

NAVIGANT
CONSULTING

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EXECUTIVE SUMMARY

In 2005, the Texas Legislature enacted Senate Bill 1188, which directs the HHSC to assess, review and undertake optimization of case management programs and services across the HHSC enterprise. Optimization efforts are to 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 Texas Health and Human Services Commission (HHSC) contracted with Navigant Consulting, Inc. for assistance in the optimization of the State's case management services. This report responds to Section 2.4.1.2 of the HHSC RFP, which indicates that the contractor will review case management literature, studies, practices and trends and discuss studies of case management, case management optimization in other states, best practices in case management including outcomes for specific populations served and emerging trends in case management, including public and private policy and practice.

To fulfill this requirement, Navigant Consulting performed a literature search that included case management organizations' websites, Federal and state reports and websites as well as relevant journals. We also relied on our experience and interviews with state representatives to prepare this report. We have also highlighted Texas case management programs viewed as best practices. A more detailed description of Texas case management programs may be found in our report entitled, *Analysis of Current Case Management System*.

In trying to identify "best practices" in case management, we have found that the literature describing case management programs focuses on new and emerging practices that support general philosophies in the delivery of services. Recent trends emphasizing client empowerment, self-determination and person-centered care strategies that shift the decision-making balance in favor of the client and his/her family take center stage in many of these best practices.

Summary of Findings

Case management services are provided in both the public and private sectors, and are defined and provided differently based on consumer needs. In the private sector, much of case management has operated within the context of, first, cost containment, and more recently, managed care and disease management. With the move toward consumer-driven care, consumers "self-direct", relying heavily on disease management, wellness and other care management programs to help them manage their health and care.

In the public sector, although not all case management services are funded by Medicaid, Medicaid has been responsible for how many of these programs operate. Sections 1915(c) and (g), as well as section 1903 (a) of the Social Security Act, have provided the regulatory basis for the establishment of many case management programs.

- Section 1915(c) allows states to deliver home and community-based services as an alternative to Medicaid reimbursable institutional services; these waivers are limited to one of the following targeted groups: aged or persons with a disability or both, persons with mental retardation or a developmental delay or both and persons with a mental illness. The Centers for Medicare and Medicaid Services (CMS) instructions indicate that case management services are services that assist participants in gaining access to needed waiver and other state plan services, regardless of the funding sources for the services to which access is gained.

- Section 1915(g) authorizes states to provide targeted case management services, which may include a wide range of activities designed to help individuals obtain and retain the services they need, including monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual. Section 6052 of the Deficit Reduction Act of 2005 provided clarifications regarding coverage of certain targeted case management activities, which will continue to affect state Medicaid coverage of certain case management services.

- Section 1903(a) authorizes federal payments to states for Medicaid administrative services "necessary for the proper and efficient administration of the Medicaid State Plan." States use administrative claiming for Medicaid eligibility determination, intake processing and prior authorization to services activities.

Some public sector models are also built around managed care; even though managed care programs are not the focus of this study, we identified features of those programs that have some applicability to our work for Texas in this report. The Texas STAR+PLUS program, for example, is often referenced in the literature as an example of a state program that has successfully integrated care coordination across multiple programs using managed care models (although we note as well concerns raised by providers, advocates and insurers regarding the program's design).

Almost all states make targeted case management services available for at least one population group and all states have at least one home and community-based waiver program. Waiver programs have become the states' most-used avenue to underwrite case management and community and support services for vulnerable populations. States have begun to move from case management approaches generally targeted to individuals with specific conditions (often in acute care settings) to approaches that attempt to improve consumer access by improving the structure and functions of access entities. In recent years, CMS has been working to better meld programs, including case management, across populations. This trend may be seen in:

- Single entry point systems that enhance case management to a specific population and/or across populations – These programs enable consumers to access long-term and supportive services through one agency or organization. They help to strengthen case management with the objectives of streamlining services, avoiding some organizational duplication and reducing overall operating costs. Historically, single entry point systems have focused on one or two populations; many have controlled multiple funding sources. This report discusses single entry point systems in a number of states, including New Jersey, Minnesota, Washington and Oregon.

- "No Wrong Door" Programs – These programs, which also provide a single entry port, are emerging to integrate the delivery of social services across target populations. Under these models, case management is coordinated for those individuals and families in need of more than one service. The "No Wrong Door" program also represents the core features of many long-term care state reforms. Many states have used Aging and Disability Resource Center Grants (ADRC) to develop "No Wrong Door" programs. In these programs, the role of case managers is to clearly identify the range of services needed and preferred to support the person within the community through uniform assessments. The ultimate goal of these programs is to improve access to information and services to decrease institutionalization rates. This report discusses programs in Washington, Louisiana, Nebraska, Virginia, Wisconsin and others.

- Long-term care programs – In addition to the programs above which address the provision of long-term care services, some states are developing programs with features such as more emphasis on integrated case management activities and greater reliance on technology and administrative efficiencies. We discuss the North Carolina proposed approach and the Texas STAR+PLUS Program.

- Integrated funding models – States have demonstrated case management program design creativity in single entry point and "No Wrong Door" models. These continue to evolve, some of them under ADRC and "money-follows-the-person" grants, and have begun to more fully integrate case management, make use of common assessment tools, coordinate management information systems and other technology and combine funding to provide more coordinated care. States have

developed models that allow case managers to identify needs for all individuals, without regard to funding mechanism, emphasizing person-centered planning throughout the continuum of care. States such as Florida, as well as others discussed in this report, have used their ADRC grant to develop this program.

Texas has also implemented several of these approaches. This report discusses the Texas Real Choice System Change grant, as well as the Texas ADRC project. Texas HHSC developed these projects based on internal and external stakeholders' input on how to streamline access to community, state and federal programs and services. The Real Choice system created a "navigator function" to help consumers navigate the maze of long-term services and supports, regardless of their age or type of disability. The navigators model was implemented simultaneously in a single entry point (Texoma Real Choice) and a "No Wrong Door" (the Heart of Central Texas) framework. Navigators used common intake, referral, assessment and follow up protocols. The ADRC grant built on the successes of the navigator system and will take the integration of services to a new level through the development of an information management system. The information management system will collect data necessary to establish whether performance goals have been reached and will allow sharing client and program data between organizations.

Just as a single definition of case management is elusive, the way that states characterize their case management programs is equally so. The state programs we see here cross over, in many cases, the various categories of programs we describe above.

Case management activities (under various names) generally have two key features: providing a connection between individuals and the system of publicly-funded services and supports, and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals. Individuals who are at the highest levels of risk, with the greatest needs for social support and chronic problems, are the most likely to benefit from case management. No matter the model, however, with regard to every case management program feature we explored in this report, i.e., definition of case management services, who provides case management, determinations of qualifications for case managers, methods for paying for case management services and others, states vary, and as we have seen in Texas, programs within the same state vary. Outcomes data regarding case management services is sparse; very few programs we have seen have published information about the outcomes of case management; most of those that are published focus on the results of questionnaires and surveys.

We used information we have gathered in this study to assist in the evaluation of Texas case management programs and the development of recommendations for optimizing those services. Our recommendations integrate best practices and emerging trends from multiple states to enhance customer access and increase efficiency through a common definition of case management services, standardized qualification requirements for service providers and single entry point/"No Wrong Door" programs.

Our findings are organized into the following three sections:

- Background — Definition of case management, Social Security Act and Deficit Reduction Act Provisions (targeted case management), case manager qualifications, outcomes and payments for services.
- Public sector case management models — Single entry point, "No Wrong Door," integrated functioning models.
- Private sector case management models — Disease management, consumer-driven approach.

I. BACKGROUND

A. Definition of Case Management

Currently in Texas, case management is delivered by numerous health and human services programs and through a range of program structures and modalities. It is also referred to differently, e.g., care coordination, community support, service coordination, care management and through other terms. These multiple references to the concept of case management are not unique to Texas; we know of and could find no reference to a state that has developed a single definition of case management or a single term to refer to those services.

Case management activities generally have two key features: providing a connection between individuals and the system of publicly-funded services and supports and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals.[1] More specifically, these activities generally include:

- Targeting and outreach: Identification of clients for whom case management will be most effective
- Screening and intake: Determination of the client's eligibility for services and need for case management
- Comprehensive assessment: In-depth evaluation of the client's current situation, including strengths and limitations and need for services and support
- Care planning: Development of a care plan to include the most appropriate services and supports addressing all the needs identified during the assessment process
- Service arrangement: Provision of information, referrals or actively arranging client's access to services and supports
- Monitoring: Evaluation of the quality of services and supports and determination if the goals established within the care plan are being met
- Reassessment: Reevaluation of the goals and care plan developed during the comprehensive assessment

Within this framework, case management systems differ greatly as a function of the target population, the range of activities performed by case managers and the required provider qualifications. Reimbursement differs as well. For example, while screening, intake and comprehensive assessment are functions performed sequentially, sometimes by different entities, some programs integrate these functions within one single activity.

[1] Robin E. Cooper, *Medicaid and Case Management for People with Developmental Disabilities: Options, Practices, and Issues* (Revised), (National Association of State Directors of Developmental Disabilities, 2006), p.3.

The target populations for case management generally include the elderly and persons with physical disabilities, persons with development disabilities and mental retardation, children, persons with HIV/AIDS, persons with alcohol and/or drug abuse addictions, the unemployed and other at-risk populations. Individuals at highest risk of institutionalization, with the greatest needs for social support and chronic problems, are most likely to benefit from case management.[2]

The complexity of delivery systems and the diversity of their target populations create a multifaceted matrix of case management roles[3], and the case management service system focuses on roles that maximize the system's ability to respond to clients' needs.

- Within the service system, the case manager generally acts as a:
  - Broker, arranger and coordinator, who identifies and coordinates services
  - A gatekeeper, who contains costs and monitors resource allocation
  - An evaluator, who assures that case management goals are attained
- A case management client system focuses on roles that assist clients to maximize their ability to use available resources to improve their quality of life. Within the client system, the case manager generally acts as a:
  - An educator
  - A counselor
  - A monitor
- The case manager also acts as a mediator between the system and the client and as an advocate on the behalf of the client. Depending on the health care setting and the target population, some of these roles might be more common than others. For example, a case manager in a long-term care system fulfills mostly the roles of broker/arranger, service coordinator, advocate, counselor and gatekeeper.

The definition of case management continues to evolve. For example, **Louisiana's "**No Wrong Door" approach, discussed later in this report, speaks of "integrated case management," whereby there is a team approach to assessing the needs of a client and if applicable, the family, establishing a comprehensive plan for addressing all those needs and using service integration to deliver required services. Service integration means a process by which a range of social services is delivered in a coordinated and seamless manner to provide client-oriented services,

[2] Andrew E. Scharlach, et al., Case Management in Long-Term Integration: An Overview of Current Programs and Evaluations (University of California, Berkley, Center for the Advanced Study of Aging, 2001), p.12.
[3] Scharlach, p.13.

increase early intervention and prevention opportunities, improve client outcomes and establish provider accountability through performance measures.[4]

Recent trends emphasizing client empowerment and self determination have also added new dimensions to the role of the case manager, such as "support broker" or "personal agent." The new role implies developing person-centered care strategies that would shift the decision-making balance in favor of the client and his/her family. In its RFP, HHSC defined person-centered case management as "case management driven by the persons in need of case management, with the support of families, as appropriate. The persons in need of case management direct the planning to meet their own life visions and goals. Person-centered case management is based on a person's preferences and needs, includes the person's responsibilities and increases the person's capacity to manage their own needs."

While the definition of case management varies, it is important to note the role that Medicaid regulations regarding coverage and funding, provider qualifications and payment have significantly affected how case management programs are designed.

B. Social Security Act Provisions for Case Management

Before the 1980s, the Medicaid program funded only two categories of case management services:

- Administrative services: Designed to determine the eligibility for Medicaid services, help beneficiaries locating Medicaid services and, to a limited extent, monitor the provision of services
- Case management activities: Provided in conjunction with the delivery of a Medicaid-funded service

Three different legislative reforms of the Social Security Act authorized the coverage of case-management as a "stand-alone" Medicaid service: Section 1915(b) of the Social Security Act, Section 1915(c) of the Social Security Act and Section 1915(g) of the Social Security Act.

Section 1915(b) of the Social Security Act permits states to obtain waivers to operate "primary care case management services." The discussion of these services is not within the scope of this engagement.

Section 1915(c) of the Social Security Act allows states to deliver home and community-based services (HCBS) as an alternative to Medicaid reimbursable institutional services (i.e., services provided in a hospital, nursing facility or ICF/MR). HCBS waivers are limited to one of the

[4] House Bill No.1613, Regular Session 2003. Available online: http://www.legis.state.la.us/leg_docs/03RS/CVT2/OUT/0000K3A3.PDF.

following targeted groups or any subgroup that the State may define: aged or persons with disabilities or both, persons with mental retardation or developmentally disabilities or both and persons with mental illness. States have flexibility in establishing targeting criteria consistent with this regulation. A state is required to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan.

Section 1915(c) identifies case management as a part of the services that can be offered through an HCBS waiver program. However, it does not provide a definition for the term. States propose their own definition that must gain Federal approval. The Center for Medicaid and Medicare Services (CMS) developed a waiver template for states to use when submitting a HCBS waiver request. The most recent (2006) instruction guide accompanying the template defines core case management services as the following: "Services that assist participants in gaining access to needed waiver and other state plan services, regardless of the funding sources for the services to which the access is gained." [5] Under an HCBS waiver, these activities may include:

- Evaluation and/or reevaluation of level of care
- Assessment and/or reassessment of the need for waiver services
- Development and/or review of the service plan
- Coordination of multiple services and/or multiple providers
- Monitoring the implementation of the service plan and participant health and welfare
- Addressing problems in service provision
- Responding to participant crises
- Determining the cost neutrality of waiver services for an individual[6]

Most state waiver programs define the scope of case management services as described in this waiver guide. In some states, however, case managers also play distinct roles in responding to and addressing crisis situations, especially in terms of behavioral health services.

States may choose to provide varying types and intensity of case management services to individuals, based on an assessment of individual needs. All states have one or more Medicaid

[5] CMS," Application for a §1915 (c) HCBS Waiver - Version 3.4: Instruction, Technical Guide and Review Criteria," (November, 2006), p.132. Available online: http://www.hcbs.org/files/100/4982/Final_Version_3_4_Instructions_Technical_Guide_and_Review_Criteria_Nov_2006.pdf.

[6] CMS, Application for a §1915 (c) HCBS Waiver, p.276.

HBCS waivers for certain groups of Medicaid beneficiaries. In 2003, states paid more than $18.9 billion for 919,000 individuals in HCBS programs.

Section 1915(g) of the Social Security Act authorizes states to provide "targeted case management services" on a free-standing basis, as a regular benefit under their state Medicaid plans. Section 1915(g) was modified by the Omnibus Reconciliation Act of 1987 and the Deficit Reduction Act (DRA) in 2005 to clarify the circumstances under which Medicaid payments may be claimed.

The provision of targeted case management services is optional for states. States that cover targeted case management services under their Medicaid plan must define the target population, the scope of activities and the providers and provider qualifications.

The Medicaid program requires that any service included within the state program must be available to all Medicaid recipients. However, Section 1915(g) of the Social Security Act allows states to limit the delivery of targeted case management to specific groups of Medicaid recipients.[7] The state must indicate any limitations of disease or condition, age, institutional or noninstitutional status or other characteristic(s) by which the target group is identified. When a state plans to serve different populations it must separate definitions of the services and qualifications of providers for each target population. This provision permits states to define program goals and objectives to respond to the specific needs of a particular Medicaid population. Once the target population is defined, all Medicaid recipients who meet the specified requirements are entitled to receive targeted case management services. Individuals receiving case management services through another Medicaid program are not eligible for targeted case management services.

The state also must define case management services as they apply to the target population, specify any limitations that apply to services and indicate the unit of service. CMS does attempt to define targeted case management services, indicating that these services may include a wide range of activities designed to help individuals obtain and retain the services they need, including "monitoring and follow-up activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the individual."[8]

According to CMS recommendations, states can use targeted case management as an avenue to implement the Olmstead decision.[9,10] States can provide targeted case management to

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[7] Robert Mollica and Jennifer Gillespie "Targeted Case Management Discussion," (Rutgers Center for State Health Policy/National Academy for State Health Policy, 2004.) Available online: http://www.cshp.rutgers.edu/TACCMSconfPapers/MollicaGillespieTargetedCaseMgt.Pdf.

[8] Section 1915(g)(2)(A)(IV) of the Social Security Act, as added by Section 2052 of the Deficit Reduction Act of 2005 (P.L. 109-171).

[9] CMS, "Olmstead Updates No.3, HCFA Update" (CMS, July 25, 2000.) Available online: http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf.

[10] Supreme Court decision in Olmstead v. LC (1999) is an interpretation of Title II of the Americans with Disabilities Act (ADA) that affirms the right of people with disabilities to receive services in the most integrated setting

institutionalized persons who are relocating to the community to facilitate the transition process and enable these persons to gain access to needed medical, social, educational and other services in the community. Targeted case management may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition.

Although there are no major differences at a practical level between targeted case management activities and HBCS case management services, many states choose the targeted case management option as it allows Medicaid financing for a larger population, while HCBS case management services are restricted to waiver participants.[11]

The state has the responsibility to specify the qualifications of individuals and agencies providing targeted case management services. Section 1915(g) does not contain any federal requirements for provider qualifications. States can limit the number of targeted case management providers to agencies designated by state or regulations only for individuals with developmental disabilities or chronic mental illness. This provision facilitates the alignment of targeted case management coverage with the existing case management service system. States that delegate the provision of services to a single entry agency are most likely to take advantage of the targeted case management option. [12]

C. Deficit Reduction Act Provisions for Case Management

Section 6052 of the DRA provides new clarifications regarding Medicaid coverage of targeted case management services.[13] The new statutory provisions retain the existing definition of case management services as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services." The definition specifies a variety of activities that are eligible for Federal reimbursement, such as service needs assessment, development of a care plan, referral to assist the individual to obtain needed services, monitoring and follow-up activities.

Although Medicaid reimbursement may also be claimed for assisting individuals to obtain and retain services whether or not such services are Medicaid-funded, Section 6052 of the DRA specifically excludes from the definition "the direct delivery of an underlying medical, educational, social or other service to which an eligible individual has been referred," and identifies a number of activities related to the delivery of foster care services that cannot be claimed as case management services. These services are:

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appropriate to their needs. The decision recognizes that unnecessary segregation of persons in long-term care facilities constitutes discrimination under the ADA.

[11] Cooper, p.17.

[12] Cooper, p.49.

[13] 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).

- Researching, gathering and completion of documentation required by the foster care program
- Assessing adoption placements
- Recruiting or interviewing potential foster care parents
- Serving legal papers
- Home investigations
- Providing transportation
- Administering foster care subsidies
- Making placement arrangements

Section 6052 specifies that services for individuals who are not eligible for medical assistance under the State plan, or who, if eligible are not part of the target population specified in the state plan, will be considered for targeted case management services if the scope of services is directly related to the management of the eligible individual's care. Services employed in the identification and management of noneligible or nontargeted individual's needs and care will not be considered allowable targeted case management.

Section 6052 also requires states to bill other funding sources that are obligated to pay for targeted case management first, before charging Medicaid, in accordance with Section 1902(a)(25) of the Social Security Act. If targeted case management services are reimbursable by another federally-funded program, the state would be required to allocate the costs of these services as required by federal regulations.

The provisions of Section 6052 of the DRA were effective January1, 2006. Various stakeholders stated that the DRA's provisions indicating that "Federal financial participation is available only if there are no third-parties liable for care," were confusing and discouraged entities from providing targeted case management to populations who are not eligible for Medicaid. [14] Although CMS has not released additional guidance on section 6052, on December 15, 2006, it wrote to State Medicaid Directors to provide guidance on DRA section 6035. DRA section 6035 amended section 1902(a)(25) of the Social Security Act to specify which parties are considered "third parties" and "health insurers" that might be liable for payment and that cannot discriminate against individuals on the basis of Medicaid eligibility. Section 6035(a) clarifies that "third parties" include self-insured plans, pharmacy benefits managers and other parties that are, by statue, contract, or agreement, legally responsible for payment of a claim for a health care item or service. CMS interprets the "other parties" to include entities such as: third-

[14] Jane Perkins, "The Deficit Reduction Act of 2005: Implications for Advocacy." (National Health Law Program, 2006). Available online: www.healthlaw.org/library.cfm?fa=download&resourceID=82983&print.

party administrators, fiscal intermediaries and managed care contractors. States are required to submit a Medicaid state plan amendment providing assurance that laws imposing specific requirements on third parties are enacted.

The Congressional Budget Office estimated that the provisions of the DRA would reduce the Federal Medicaid funding for targeted case management by $760 million between 2006 and 2010. The Texas Health and Human Services Commission (HHSC) estimated that due to these changes the Department of Family and Protective Services would lose $82 million in Medicaid case management reimbursement.[15] HHSC anticipated that only $32 million of the lost funds will be eligible for coverage under Federal Title IV-E. Furthermore, the President's FY2008 budget plan contains a legislative proposal that would reduce the targeted case management matching rate to 50 percent. The current rate for Texas is 61 percent.

Case management services (targeted case and primary care case management) covered by Medicaid were available to 2,363,000 persons and accounted for approximately $2.75 billion of Medicaid expenditures.[16] Almost all states (48) make targeted case management available at least for one population group and the majority of states offer targeted case management services to a number of different groups, including:[17]

- Beneficiaries with specific medical conditions or reportable communicable diseases such as asthma, diabetes, HIV/AIDS
- Elderly or beneficiaries with disabilities of any age at risk of institutionalization due to multiple physical or mental diagnoses, including those who are medically fragile and technology dependent and/or with very costly health care needs
- Severely emotionally disturbed or neurologically impaired children
- Beneficiaries of varying ages with substance abuse problems, chronic mental illness and/or developmental disabilities, including those who may be transitioning to community placement
- At-risk pregnant women, or young mothers and their infants
- Children with high blood lead levels
- Beneficiaries with severe vision or other sensory impairments

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[15] Texas Health and Human Services Commission, "Deficit Reduction Act Summary." (HHSC, 2006.) Available online: http://www.hhsc.state.tx.us/news/meetings/past/2006/Council/032406_3f.pdf.

[16] Karen Triz, "Medicaid's Home and Community-Based Services State Plan Option: Section 6086 of the Deficit Reduction Act of 2005." (CMS Report for Congress, May 26, 2006). p.3. Available online: http://www.ndrn.org/policy/DRA/CRS%20report%20HCBS%20Option.pdf.

[17] The Henry J. Kaiser Family Foundation, "Medicaid Benefits Online Databases, Benefits by Services: Targeted Case Management." (October, 2004). Available online: http://www.kff.org/medicaid/benefits/service.jsp?yr=2&so=1&cat=7&sv=40&x=81&y=17.

- Children in foster care or state custody or who are at risk of out of home placement
- Beneficiaries of any age at risk of abuse or neglect
- Refugees or immigrants having difficulty accessing health care due to language proficiency

In 2003, the State of Maine had the most comprehensive targeted case management system, offering services to 20 different defined groups. Persons with developmental disabilities of all age groups represent the population most often targeted by these services.[18]

D. Case Manager Qualifications

A case manager's level of education in a specific discipline could range from a paraprofessional to a professional trained in the field of nursing, social work, vocational rehabilitation or mental health. Case management roles and responsibilities derive from the institution's scope of practice and require different educational backgrounds and competencies. For example, a nurse case manager must facilitate the most appropriate and effective use of health care benefits. Consequently, to be effective, a nurse case manager must possess clinical expertise as well as in-depth knowledge of the health care system regulations and financing mechanisms.[19] According to the National Association for Social Workers, a social work case manager should have a baccalaureate or graduate degree from a social work program accredited by the Council on Social Work.[20] A social work case manager is responsible for assessing both the individual client's biopsychosocial status as well as the state of the social system in which case management operates.

According to the Commission for Case Manger Certification, an increasing percentage of state programs are requesting certification for case managers.[21] Currently, there are several programs, e.g., Certified Case Manger (CCM) and Care Manager Certified (CMC), offering certification credentials recognized at the national level. The certification programs require candidates to have experience in providing case management services and to pass a case management certification examination. Advocates of the practice argue that credentialing increases the quality of care by encouraging adherence to standards and a code of ethics and establishes uniform performance benchmarks across programs and states.[22]

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[18] Human Resource and Services Administration, "Medicaid Case Management Services by States." (2004). Available online: http://www.hrsa.gov/reimbursement/TA/webcast-Sept1-Case-Mgmt-by-State-040825.htm.
[19] Pamela White and Marilyn E. Hall, "Mapping the Literature of Case Management Nursing" *Journal of the Medical Library Association*, (April, 2006) 94(2 Suppl) pp. E99–E106.
[20] National Association for Social Workers, "NASW Standards for Social Work Case Management." (June 1992). Available online at http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#def.
[21] Commission for Case Manager Certification. Available online: http://www.ccmcertification.org/pages/111tour.html.
[22] Sandra Lowery, "Credentialing in Case Management: A Yardstick for Competency, Credibility, and Commitment." *ROSE Resource*, Vol.14, No.2, 2004. Available online: http://www.ingreinsurance.com/pubs/group/rose/RR2Q04.pdf.

States have wide latitude in establishing provider qualifications. CMS has not established qualifications for case management providers and states cannot narrow the pool of acceptable providers based on criteria unrelated to assuring that the service is furnished by appropriately qualified individuals or agencies; for example, a state cannot limit its contract to those who have contracted with the State at a given point in time.[23]

Under targeted case management, states may restrict providers of case management services to a single point of entry entity. This means that individual case managers must be employees of the single point of entry or under contract to these entities.

Where a state has not opted to restrict providers to a single point of entry 1915(g)1, or furnishes case management under its HCBS waiver program, the state must offer a waiver agreement to any willing qualified providers or agencies. In some states, this obligation has raised the concern that case management services might be furnished by organizations that are not well established or by minimally credentialed individuals.[24]

States can establish qualifications that require:

- Relatively high levels of education and/or experience
- Passing a competency exam
- Continuing education
- Participation in training courses
- Specific skills, e.g., case managers for individuals who are dually diagnosed might be required to have special training in services for such individuals

States can also require specific capabilities:

- 24-hour on call system
- Back-up case managers
- **Indiana, Florida and Michigan** require in their single entry point systems for long-term care that agencies or individuals who furnish case management services cannot be affiliated with agencies that also furnish direct services
- Differentially credentialed case managers for different target populations (brain injury, autism)

[23] CMS, Application for a 1915(c) HCBS Waiver, pp. 111, 276.
[24] Cooper, p.41.

A recent trend in the mental health community promotes the delivery of case management services by trained peer specialists. The President's New Freedom report acknowledges that "consumers who work as providers help expand the range and availability of service and supports that professionals offer."[25] Several studies have identified positive effects of peer specialists on Assertive Community Treatment (ACT) teams and other intensive case management teams for individuals with severe mental illness.[26] A study comparing the outcomes associated with a consumer-staffed ACT team versus a non-consumer ACT team showed that consumer-run ACT team clients had fewer hospitalizations and emergency room visits and a shorter time to homelessness. **Georgia** was the first state to implement successfully an independent peer support services program that bills Medicaid directly; approximately 9 other states reference peer support services in their Medicaid rehabilitation rules. Services target consumers with severe and persistent mental illness. These consumers may have concomitant substance abuse disorders or concomitant mental retardation.

Candidates for peer certification in Georgia must be consumers or former consumers of mental health services, be well-grounded within their own recovery experience and hold a high school diploma. The certification process requires participating in an eight-day training program and passing a written and oral exam.[27] The Peer Specialist Certification Project also conducts ongoing training at least two times a year and holds quarterly continuing education seminars and workshops for those already certified. Currently, Georgia has a work force of nearly 200 certified peer specialists. **Arizona**, **New York** and **South Carolina** have also developed a strong work force of peer specialists.[28]

E. Outcomes

Given the multidisciplinary nature of case management, established quality practices and measurement tools also vary greatly across programs and state systems. Most quality measurements will assess to what degree the program achieved its intended outcomes. General categories of desired outcomes across programs serving different populations focus on:[29]

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[25] President's New Freedom Commission on Mental Health, "Achieving the Promise: Transferring Mental Health Care in America." (President's New Freedom Commission on Mental Health, 2003.) Available online: http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/New_Freedom_Commission/Default1169.htm.

[26] Assertive Community Treatment is a way of delivering comprehensive services to individuals who have been diagnosed with severe mental illness and who have needs that have not been met by traditional approaches to service delivery. Services are customized to the individual needs of the consumers, delivered by a team of practitioners and are available 24 hours a day.

[27] Larry Fricks, "Medicaid Funded Peer Support Services and the Training and Certification of Peer Specialists." (Georgia Certified Peer Specialist Project Webinar.) Available online: http://www.gacps.org/files/webinar4A.ppt#260,5,The State of Georgia and the Peer Supports Project.

[28] Center for Health Policy and Research, "Developing a Mental Health Peer Specialist Workforce in Massachusetts," 2006.

[29] Scarlach, p. 50.

- Cost-effectiveness and cost containment: Studies examining the cost-effectiveness of case management did not identify consistent patterns.

- Service utilization: A randomized experimental demonstration for people 65 and older who were functionally impaired showed that integrating health and case management services does not significantly reduce nursing home utilization or hospital use. However, this integration led to a substantial increase in the use of formal community services.[30]

- Participant's physical, mental and social functional capacity: Studies did not identify consistent patterns related to functional capacity.

- Family functioning and quality of life, including autonomy, psychological well-being and satisfaction: The provision of case management services is correlated with a decrease in caregiver strain and an overall increase in social/psychological well-being.

Within HCBS programs, given that the Federal requirements do not define HCBS quality assurance standards, the CMS has limited information on the programs' quality of care. In 2003, the United States General Accounting Office (GAO) analyzed 1992-1999 state reports for waivers serving the elderly to evaluate HCBS quality of care outcomes. The GAO identified "inadequate case management" as one of the most prevalent quality of care problems. The information on case management services mostly was obtained from audits of agencies responsible for case management, including reviews of samples of case managers' records to ensure timeliness and completeness. Examples of case management problems included case managers who:

- Were unaware of beneficiaries having lapses in delivery of care

- Were not always aware of procedures of protocols for reporting abuse, neglect, or exploitation

- Failed to complete resident assessment – service plans were either incomplete or inappropriate and updates to plans of care were late

[30] The National Long-Term Care Channeling Demonstration (1980-1986) was a Federal initiative designed to test the feasibility and cost-effectiveness of an alternative community-based long-term care service delivery concept integrating health and social services. The demonstration superimposed a coordinating and accountability mechanism--case management--onto the existing system of services and client eligibilities. Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, and Texas implemented the channeling demonstration.

- Did not always appear to have a clear understanding of services definitions or requirements of the Waiver or Medicaid program[31]

[31] United States General Accounting Office, "Long Term Care, Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened" (GAO, Washington, 2003), p. 22.

A literature review in a study conducted by the National Academy for State Health Policy suggests the following outcome indicators:[32]

- Improved patient experience
- Improved family experience
- Decreased family caregiving burden
- Improved provider experience
- Maintenance or improvement of functional well-being, independence and community participation
- Maintenance or improvement of health status
- Prevention of secondary complications

While we have found numerous studies regarding the outcomes of waiver programs, we found very little information about outcomes related directly to case management provisions provided within these programs, either in a literature search or through our contacts with state agency representatives. Many individuals we interviewed steered us toward consumer surveys or measures of the number of encounters. Program surveys measure case management outcomes mostly in terms of patient satisfaction with the delivery of services (e.g., if the patient was treated with respect, if the information provided was helpful, etc.). We have learned that a few of the recent programs sponsored by the Aging Disability Resource Center (ADRC) grants will be examining case management outcomes. However, these programs are still too new and evaluations have not been completed.

F. Payments for Services

Medicaid funding for case management falls into two categories, payment for the service itself and payment for services that fall under administrative claiming.

Fee-for-Service

When Medicaid funding for case management is obtained through service claiming (as required under the HCBS or targeted case management option), states generally determine the unit of service in one of the following ways:

- Time – The case manager tracks the time spent with a consumer, usually in 15- or 30-minute increments.

[32] Robert L. Mollica and Jennifer Gillespie, "Care Coordination for People with Chronic Conditions" (*National Academy for State Health Policy*, January 2003).

- Encounter, or contacts – Providers record each discrete activity that a case manager conducts as a contact.

- Monthly fee – Some states pay a flat amount per month per individual.

Each of these approaches has its own advantages and disadvantages. For example, using 15- or 20-minute increments, states have determined that overutilization to increase payments may be an issue. On the other hand, paying a monthly fee could create incentives for underutilization. For some services, such as Assertive Community Treatment (ACT) for individuals for severe and persistent mental illnesses, requiring 15-minute units may not reflect overarching service delivery models or philosophies. Nevertheless, some of our clients are being advised by CMS that they should move to billing in 15-minute increments for targeted case management services.

Administrative Claiming

Section 1903(a) of the Social Security Act provides Federal payments to states for activities performed to properly implement the State Medicaid Plan. Such payments are not service payment in the sense that a state makes a claim for a discrete set of services furnished to specific eligible recipients. These payments, referred to as "administrative claiming" provide Federal financial participation for the costs that the Medicaid or other agency incur in the "proper and efficient operation of a State Medicaid Plan." Some common 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.[33] An important distinction between administrative claiming for case management services and covering case management as a "service" under the HCBS waiver program or the targeted case management option is that Federal financial participation in case management as an administrative expense is limited to only costs that arise in assisting individuals to gain access to Medicaid-funded services.

[33] Cooper, p.18.

II. PUBLIC SECTOR CASE MANAGEMENT MODELS

States have developed case management systems that are often very similar to those seen in the private sector. For example, acute care health services case management programs developed around specific diseases (e.g., diabetes, childhood asthma) have become commonplace within Medicaid programs across the country through the spread of managed care delivery systems.

States have more far-reaching opportunities for case management, however, across acute and long-term care services, across funding streams and across target populations.

Home and community-based waiver programs have become the states' most-used avenue to underwrite case management and other community and support services for vulnerable populations: the frail elderly, individuals with physical disabilities, individuals with physical disabilities, individuals with mental retardation and development disabilities, medically fragile or technologically dependent children, individuals with HIV/AIDS and individuals with traumatic brain and spinal cord injury. In 2003, almost a million persons received services thorough 257 waivers under the Medicaid 1915(c) program.[34]

Using the 1915(c) waiver option, states have developed a wide range of case management models. Until recently, these models reflected the population-based nature of most 1915(c) waivers. Therefore, as a waiver was designed for a specific population, the case management service developed around the needs of that population within that specific waiver. In recent years CMS and states have been working to better meld programs, including case management, across populations. For example, this trend may be seen in:

- Single entry point systems that enhance case management to a specific population and/or across populations
- "No Wrong Door" programs, including Aging and Disability Resource Center (ADRC) Grant programs
- Long-term care programs
- State programs that bring together case management across funding sources

We describe some of the specific models below.

[34] Most recent data collected from Kaiser Commission on Medicaid and the Uninsured, Medicaid 1915 (c) Home and Community-Based Service Programs: Data Update (December 2006). Available online: http://www.kff.org/medicaid/7575.cfm.

A. Single Entry Point Systems

When case management systems are dispersed through various departments and agencies, effective coordination is difficult. Consumers and families become confused and have difficulties obtaining needed services. Single entry point systems allow consumers to access services through one agency or organization that conducts screening, assessment and case management activities. However, the single entry point is not a single, physical, geographic location. Multiple agencies can be designated as the single entry point or a single local or regional agency with multiple locations across a state can perform this function. When multiple agencies act as the single entry point, they coordinate with each other to integrate access to services through a single, standardized entry process. For example, in **Minnesota**, county agencies are a single entry point for seven different target populations, while the Minnesota Centers for Independent Living serve only four target populations and Area Agencies on Aging only three.

Single entry systems vary considerably in scope and implementation. A state can choose to integrate services horizontally (consolidating or coordinating access to diverse services across authorizing agencies and providers) or vertically (linking all services from all sources from the time a consumer requests services up to the provision and monitoring of those services.) A single entry point in a specific state can facilitate access for one or more target populations to one or more (not necessarily all) programs and funding streams. Some states have parallel single entry points for different populations. In **Pennsylvania**, the Area Agencies for Aging are single entry points for older adults; county departments are the entry points for Mental Retardation and Developmental Disabilities (MR/DD) and community centers are the entry points for physical disabilities, traumatic brain injury and people who are technologically dependent. On the other hand, in **Wisconsin**, county departments serve older adults, people with physical disabilities, MR/DD and people with traumatic brain injury.[35]

Historically, case management systems have focused on one or two service populations.[36] In 2003, the Rutgers Center for State Health Policy/NASHP Community Living Exchange Collaborative conducted a survey of the 50 states and the District of Columbia to identify states that operate single entry point systems and to describe the characteristics of the single entry points. While this study is a bit dated, it is useful in understanding the case management models that have been used throughout the United States and as a starting point to review their evolution.

The Rutgers study defined a single entry point system as one that enables consumers to access long-term and supportive services through one agency or organization. The study found that,

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[35] Robert Mollica and Jennifer Gillepsie, "Single Entry Point Systems: State Survey Results."(Rutgers Center of State Health Policy/National Academy for State Health Policy, 2003. Available online: http://www.nashp.org/Files/SEP_Report_08.29.03.pdf.

[36] Mollica and Gillepsie.

at the time of the study, 32 states and the District of Columbia reported 43 single entry points. Relevant findings included:

- Single entry points performed a range of functions. Most developed care or individual service plans and monitored service delivery. Most also completed assessments, authorized services and completed periodic reassessments. Seventeen single entry point systems determined financial and functional eligibility. Twenty-four conducted nursing facility preadmission screening.

- Twenty-four single entry point systems served older adults; 11 of the 18 that served a single population served people with MR/DD only. Twenty-five served two or more populations.

- State agency field offices were the type of organization that most frequently operated as the single entry point, followed by community-based nonprofits and Area Agencies on Aging.

- All but one provided access to Medicaid HCBS funded programs, 35 provided access to programs funded by state general revenues and 26 managed services listed in the State Plan.

While the study noted some common features of the single entry points, i.e., most served two or more populations, most controlled multiple funding sources and most required a case manager to have a minimum of a bachelor's degree, there was also considerable variation in the functions they performed, the populations they served and the organizations that functioned as the single entry point.

This study's conclusions continue to have relevance for case management program design:

- Single entry points that serve multiple populations may achieve economies of scale and streamline single entry point/provider agency relationships. The survey identified multiple examples of single entry points serving older adults and adults with physical disabilities, however, only a few of those included services for people with mental retardation and developmental disabilities or other populations. Single entry points that serve people with mental retardation and developmental disabilities tend to serve those populations exclusively.

- Combining financial and functional eligibility determinations or improving coordination would expedite access to home and community-based services. Yet, only 16 of the single entry points identified in this survey determined both financial and functional eligibility. The ADRC Resource Grants (discussed later in this report) support the integration of financial and functional eligibility by providing funds in the 16 states that perform both functions.

While the establishment of a single entry point implies some degree of integration of the overall system, establishing a single entry point is not the same as establishing a fully integrated system. Integrated case management, according to the National Chronic Care Consortium, involves integration of care management with an entire system of care.[37] Integrated systems offer client support and continuity across service settings and strive to eliminate duplication and fragmentation of services. Integrated case management models exist within an interdisciplinary organizational structure that strives to provide all necessary services for clients.

Supporting an integrated system is the use of common assessment tools for screening and eligibility for HCBS; coordination of an information management system designed to produce usable information for policy development, planning and resource allocation; and coordination of planning, policy development and resource allocation to ensure that all decisions that impact the system are made with the full knowledge and participation of affected programs and divisions. The e-Texas Commission envisioned the creation of single entry points with advanced information technology tools. The Commission specified "for government, advanced information technologies will allow the state to provide families with a single point of entry for obtaining children's health care, mental health care, long-term residential care and adoption and foster care services.[38]"

Navigant Consulting identified several states with single entry points, some focused on a single target and others focused around a combination of target populations as examples of this model.

- Point of entry around specific target populations (e.g., elderly persons, people with physical disabilities; people with developmental disabilities). Under this model, the point of entry entity serves individuals with all disabilities; a single case manager assesses all of the individual's needs. The single entry point creates a "one-stop shopping" model that enables individuals regardless of their disability to access HCBS through the designated single entry point.

  The agency responsible for the single point of entry is typically responsible for services such as intake and eligibility determination and ensuring that services are appropriate to meet the needs of consumers. **Indiana**, for example, implemented the CHOICES HCBS waiver program for Medicaid long-term care services and designated the network of Area Agencies on Aging to perform case management services for the waiver program. The main scope of the Areas Agencies on Aging is to manage programs funded under the Federal Older Americans Act. By integrating waiver services within this structure, the state built a new program using the existing expertise.

[37] Richard Bringewatt, "Integrating Care for People with Chronic Conditions," National Chronic Care Consortium, 1995. p.29.
[38] E-Texas Commission, "Report of the e-Texas Commission." (e-Texas Commission, December 2000.) Available online: http://www.cpa.state.tx.us/etexas2001/report/ch09/.

The **New Jersey Child Behavioral Health System of Care** is a statewide system which provides services to children and adolescents with emotional and behavioral healthcare needs.[39] In this system, the goal of case management is to provide integrated linkages between agencies serving children and assurances that multiple services are provided in a coordinated manner. In addition, the system is designed to provide coordinated behavioral health regardless of funding source or entry point into the system.

The New Jersey Child Behavioral Health System of Care has a single statewide entry point that offers care coordination and utilization management to children. This entry point is referred to as the Contracted System Administrator and is a private entity under contract with the State. The Contracted Service Administrator is used by children entering the system from a variety of programs and funding sources, including the Division of Behavioral Health Services, Division of Youth and Family Services, the Juvenile Justice System and directly from their family home. The Contracted Service Administrator assists in needs assessment and coordination with community organizations (e.g., schools). Regional Care Management Organizations also exist as contracted entities throughout the State and offer more intensive case management to children. As of March 31, 2004, almost 17,000 were enrolled in this system of care and approximately 1,400 received additional case management through care management organizations.

- Point of entry around a combination of target populations. Under this model, the point of entry entity serves multiple target populations.

  The **Minnesota** single entry point system, for example, provides services across different populations with disabilities through county human services agencies. These populations are not limited to populations eligible for services under HCBS waivers. The Minnesota single entry point system is organized around county agencies that are the single entry point for all types of publicly funded services: public assistance, social services, health and long-term services. County governments have specific legal responsibilities for administering programs related to case management functions, regardless of Medicaid eligibility. Counties are responsible for the following case management "gate-keeping" functions: eligibility outreach, screening, intake, screening and assessment. Counties are also responsible for service coordination including planning; identification of available and appropriate services; coordination of services across multiple programs, agencies and assessments; advocacy; monitoring and on-going monitoring.[40] The structure of the information and referral function integrates specialty telephone lines, a mechanism for

[39] Program description available online: http://www.state.nj.us/dcf/behavioral.
[40] Minnesota Department of Human Services, "Case Management in Minnesota: A Report to the Minnesota Legislature." (February, 2003.) p.9. Available online: http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_026864.pdf.

consultants and consumers to meet face-to for planning and an extensive database (MinnesotaHelp.info.) of community resources used by professionals and consumers alike. The database allows consumers, case managers and providers to explore the service options available in any community within the State, including housing, human services, disability services, prescription drug assistance and translation assistance.

Counties are also responsible for defining and enforcing regulations regarding case managers' qualifications. For example, for persons accessing case management services under the HCBS waivers, the Minnesota Disability Program Manual for Waiver Case Management/Service Coordinator defines case management services as "services that will assist a person on a waiver to gain access to needed waiver and State plan services, as well as needed medical, social, educational and other services, regardless of the funding source."[41] Depending on the waiver's target population, case management/service coordination may be provided by a public health nurse, a registered nurse, a social worker or an individual with at least a bachelor degree in social work, special education, psychology, nursing, human services or other field related to the education or treatment of the person served. According to a report reviewing the case management system in Minnesota "although the different forms of case management are very similar in form and function, there is little consistency regarding qualifications and training requirements."[42] The same report also emphasizes that the state does not have a comprehensive case management quality program and there are no clear standards for performance tied to expected outcomes.

Washington and Oregon operate single entry point systems, but do not include as extensive a population as does Minnesota.

Washington's Aging and Disability Service Administration (ADSA) is the entity managing the budget, policy and administration of all services provided to seniors, people with physical disabilities and people with mental retardation and developmental disabilities (MR/DD). Services are available under five HCBS waivers: the Community Options Program Entry System (COPES) waiver for senior and adults with physical disabilities and four MR/DD waivers. Individuals covered by these programs receive information on all publicly-financed programs and can apply for cash assistance, food assistance, medical assistance, nursing home, assisted living or in-home care through one agency. Case management is a crucial component of Washington's long-term service system. When an individual applies for services, a regional ADSA case manager, most often a social worker, will conduct a comprehensive assessment of need, assist with

[41] Minnesota Department of Human Services, "Minnesota Disability Program Manual for Waiver Case Management/Service Coordinator" (December 2005). Available online: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000821.

[42] Minnesota Department of Human Services, "Case Management in Minnesota: A Report to the Minnesota Legislature," p.9.

Medicaid applications and develop a care plan. Ongoing responsibility for persons who remain in their homes is transferred to the AAA. However, ongoing responsibility for persons in nursing homes, adult family homes and boarding homes rests with the regional ADSA manager.

The assessment instrument for case management services is highly-technologically based, through the CARE (Comprehensive Assessment and Reporting Evaluation) system. The CARE program has built-in algorithms for equitable care planning within and across consumer populations. The software is loaded on a laptop, allowing case managers a high degree of mobility. The tool was implemented in 2003 with intensive training for assessors and case managers. The software uses pull-down menus that do not allow blank fields and therefore, oblige case managers to take all relevant information into account during the assessment. CARE assessments were initially used for elderly and people with disabilities receiving waiver services and individuals with developmental disabilities who receive Medicaid State plan personal care services. This system is extremely beneficial for an applicant as it provides immediate information on service eligibility and availability. The system also enables ready supervision and training of personnel, quality assurance, forecasting and planning. In 2005, Washington started modifying the software to also perform assessments for consumers with developmental disabilities who receive waiver services.

These system reforms enabled the State of Washington to balance its long-term services and support system. More than fifty percent of Washington's elders and adults with disabilities were served in community and residential settings in the 2003 to 2005 period, compared with eighteen percent in 1991-1993. Approximately ninety percent of individuals with developmental disabilities are served in community settings. Washington ranked 4th among all states in the percent of Medicaid funds spent on HCBS for elder and adults with physical disabilities in 2004.[43]

Within **Oregon's** long-term care system, most AAAs have assumed the functions of the State's district offices and become the single entry point for services funded by Medicaid, the Older Americans Act and Oregon Project Independence.[44] The AAAs perform financial and functional eligibility screening for Medicaid, case management and pre-admission screening. Case managers, located within the single entry point, perform a comprehensive assessment using an automated tool, the Client Assessment and Planning System (CA/PS). The CA/PS is an automated assessment tool with algorithms that allocate

[43] University of Minnesota, "Rebalancing Long-Term Care Systems in Washington: Experience up to July 31, 2005" (Long Term Care Resource Center, 2005). Available online: http://www.hpm.umn.edu/LTCResourceCenter/rebalancing_attachments/Washington%20Case%20Study%20Long%202005.pdf.

[44] The program is funded with state general revenues and it serves persons who have similar needs as those served by the waivers, but who do not qualify for Medicaid.

an individual's need for assistance to service priority levels, automatically providing an eligibility decision.

Case managers use laptops to record the client's answers to the assessment and collect information about living environment, personal characteristics, preferences and medical status. The CA/PS also calculates the individual's priority for receiving services based on a seventeen level scale as a function of the degree of assistance the customer needs with specific daily activities. Based on this assessment, the case manager and client discuss service options and develop a care plan. Most case managers serve people living in the community who are financially and functionally eligible for public funding. A small percentage of case managers, called risk intervention case managers, assist high risk customers who do not meet public funding criteria to obtain services.

These particular system features are a part of a continuum of systemic reforms implemented since the early 1980s that enabled the State of Oregon to shift the balance of public funding from a nursing home focus to an array of community-based supports. From July 1995 through December 2004, Oregon reduced the number of Medicaid-supported individuals in nursing facilities from approximately 7,300 to 5,062, more than 30 percent. In 2005, the Oregon institutionalization rate for seniors was below three percent, the best record within the nation.

When **New York** proposed to implement a single entry point system for long-term care, the Healthcare Association of New York State developed recommendations based on lessons learned from Minnesota's and Wisconsin's implementation of a SEP system.[45] The most important recommendations were:

- Provide comprehensive information to consumers and providers through a variety of tools such as web pages, telephone hotlines and face-to-face counseling.
- Planning for long-term care and resource maximization as a follow up to discharge from an acute setting has been proven effective and to reduce costs.
- Funding under Medicaid HCBS is critical for the program's financial sustainability.
- Case coordination may not require more solutions; solutions may lie in engaging and supporting family and community in responding to people's needs.

[45] Healthcare Association of New York State," Long Term Care Reform Series: Issue Brief #1: Point of Entry", (August, 2005). Available online: http://www.hanys.org/digital_library/upload/getfile.pdf.

North Carolina is another example of a State that has implemented a single entry point across populations, but through a combined 1915(b)(c) waiver for the Piedmont Behavioral Health Program. Although this is a capitated program and provisions of the program address more than just case management, there are a few features of this program and the North Carolina service provision model worth noting in our study.

- First, the State has been transitioning area authorities from providers of mental health, substance abuse and developmental disability services to managers of these services. The State required local area authorities to divest themselves of service provision responsibilities to become Local Management Entities for all publicly funded mental health, substance abuse and developmental disability services, including Medicaid services. As a result, the private sector has taken responsibility for service provision and the Local Management Entities have assumed responsibility for authorizing and overseeing service provision.[46]

- Second, the Piedmont Behavioral Health Program covers both behavioral health and developmental disability services through a prepaid inpatient health plan model,[47] while the 1915(c) waiver allows the State to provide Medicaid financed home and community-based services (HCBS) to individuals with developmental disabilities requiring long-term supports.[48]

- Third, to obtain waiver approval, CMS requested that the State of North of Carolina change its PBH waiver design to divest case management services from PBH (the original design had called for preservation of case management for all mental health, developmental disabilities and substance abuse services at PBH) and transfer these services to community providers credentialed to provide such services.[49]

We recently completed the required evaluation of this program; however, as of the date of this writing, the results have not been published

Exhibit 1 provides information on the characteristics of five single entry point systems for states that target multiple populations.

[46] State of North Carolina, "Section 1915(b) Waiver Proposal – Piedmont Cardinal Health Plan," (July 8, 2004), p. 13.
[47] Under a 1915(b) waiver program, State of North Carolina, "Section 1915(b) Waiver Proposal – Piedmont Cardinal Health Plan," (July 8, 2004), p. 4-5.
[48] State of North Carolina, "Section 1915(c) Waiver Proposal – Independence Plus: A Program for Family or Individual Directed Community Services Waiver," (July 8, 2004), p. 3.
[49] State of North Carolina, "Section 1915(b) Waiver Proposal – Piedmont Cardinal Health Plan," (July 8, 2004), p. 13.

Exhibit 1: Comparison of Select Single Entry Point Systems

	Minnesota SEP	Washington SEP	Oregon SEP	New Jersey SEP	North Carolina SEP
Populations Served	• Older adults • Adults with disabilities • MR/DD • TBI • Children with special needs • HIV/AIDS • Mental Health • Other	• Older adults • Adults with disabilities • MR/DD	• Older adults • Adults with disabilities	• Older adults • Adults with disabilities • Other (caregivers)	• MR/DD • TBI
Designated SEP Organizations	• County Departments [50] • AAAs • CILS	• State Agency Field Offices[51] • AAAs	• State Agency Field Offices • AAAs	• AAAs	• Local Mental Health Authorities

[50] County Departments are SEP for all populations, AAAs for older adults, adults with disabilities, MR/DD, CILS for adults with disabilities, MR/DD, TBI, children with special needs.

[51] Washington SEP splits functions for older adults and adults with disabilities among organizations; State Agency Offices complete all functions except for monitor service delivery and complete reassessments, functions performed by Area Agencies on Aging.

Exhibit 1: Comparison of Select Single Entry Point Systems, *continued*

	Minnesota SEP	Washington SEP	Oregon SEP	New Jersey SEP	North Carolina SEP
Functions	• Information and referral: web based, by telephone, written materials • Screening • Nursing facility preadmission assessment screening, ICF/MR preadmission screening • Determine financial eligibility • Determine functional eligibility • Develop care plan • Authorize service • Monitor service delivery • Complete reassessment • Provide and identify protective services	• Information and referral: web based, by telephone and written materials • Screening (excluding DD/MRD) • Nursing facility preadmission assessment screening, ICF/MR preadmission screening • Determine financial eligibility (excluding DD/MRD) • Determine functional eligibility • Develop care plan • Authorize service • Monitor service delivery • Complete reassessment • Provide and identify protective services	• Information and referral: by telephone, written materials • Screening, • Nursing facility preadmission assessment screening • Determine financial eligibility • Determine functional eligibility • Develop care plan • Authorize service • Monitor service delivery • Complete reassessment • Provide and identify protective services	• Information and referral: by telephone, written materials • Screening, • Nursing facility preadmission assessment screening • Determine functional eligibility • Develop care plan • Authorize service • Monitor service delivery • Complete reassessment	• Information and referral: by telephone, written materials • Screening, • ICF/MR preadmission screening (MR/DD) • Determine functional eligibility • Develop care plan • Authorize service • Monitor service delivery • Complete reassessment
Sources of Funding[52]	• Medicaid state plan • Medicaid HCBS • State general revenue • Social Services Block G rant • County general revenue • Others	• Medicaid state plan • Medicaid HCBS • State general revenue	• Medicaid state plan • Medicaid HCBS • State general revenue	• Medicaid state plan • Medicaid HCBS • State general revenue • Social Services Block Grant • Older Americans Act	• Medicaid state plan • Medicaid HCBS-(MR/DD) • State general revenue • Social Services Block G rant

[52] The listed sources of funding are available to all populations, unless otherwise specified.

B. "No Wrong Door" Systems

As seen earlier, single entry point systems can more effectively deliver case management services to targeted populations. However, more recently, the concept of the "No Wrong Door" has emerged to integrate the delivery of social services across target populations. Under these models, case management is coordinated for those individuals and families in need of more than one service.

"No Wrong Door" systems provide a single access portal to needed services, regardless of one's disability. For such states, case management is becoming a consistent and standardized single service that is available to anyone eligible in the Medicaid-funded population. As a result, individuals may have differing disabilities or health care needs, but they are guaranteed a consistent and uniform response wherever they seek case management services. There are no "wrong doors" through which to enter.

Some states, like **Illinois** and **New York**, are in the early stages of considering how to create a "No Wrong Door" system. The Real Choice Systems Change Grants from CMS offered states the opportunity to develop an infrastructure to enhance service coordination across multiple subpopulations.[53]

The "No Wrong Door" approach creates an accessible, integrated and comprehensive continuum of services for populations with multiple needs, by increasing the ability of case managers to plan and coordinate their services. "No Wrong Door" pilot programs implemented across the United States (e.g., **Washington, Louisiana, Virginia**, etc.) have the following common traits:

- A multidisciplinary team, comprised of program staff members, natural supports to the client and the client or advocate to develop an integrated service plan
- A client-centered integrated service plan, based on the client's strengths, risks, service desires and needs

[53] The New Freedom Initiative was announced by President Bush on February 1, 2001, and is a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. It represents an important step in working to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live and participate in community life. This initiative supports states' efforts to meet the goals of the Olmstead v. L.C. Supreme Court decision issued in July 1999 that require states to administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA). CMS provides some opportunities for funding to assist in implementing systemic changes to better serve individuals with disabilities in the setting of their choosing. Money Follows the Person Demonstration Grants are part of a comprehensive, coordinated strategy to assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems. These grants will assist States in their efforts to reduce their reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities. Real Choice Systems Change grants support infrastructure changes that will result in effective and enduring improvements in community long-term support systems.

- Cross-training among the multidisciplinary team, to ensure a general understanding of each other's services and processes
- A lead case manager to coordinate the joint planning and coordinated delivery of services for the client
- Monitoring and evaluation of the service plan, services and outcomes to allow the team to make model changes as appropriate
- Flexible use of funding among offices, and if applicable, departments and community programs, to ensure that the client receives services for which he or she is eligible
- A site that permits co-location of the multidisciplinary team to make it easier for the client to obtain services and to allow the multi-disciplinary team to collaborate efficiently. If co-location is not possible, the team members shall provide a seamless link with the other team members and resources[54]

The "No Wrong Door" system encourages state agencies to:

- Communicate and exchange data and information
- Cooperate and assist each other giving general support, information or endorsement for each others programs
- Coordinate and engage in joint planning, activities, goals, objectives and events
- Collaborate and renounce some of their autonomy to achieve the proposed common outcomes
- Integrate and restructure services, programs, memberships, budgets, mission and staff
- Consolidate behaviors, operations, policies, budgets, staff and power in order to develop and achieve common goals[55]

The State of **Nebraska**, for example, used its Real Choice Systems grant to create a services coordination function that standardized the various components of service coordination, ranging from the coordinator's qualifications, to the allowable case loads, to the assessment tool used to measure outcomes. As a result, individuals may have differing health care and

[54] Washington State Department of Social and Health Services, "No Wrong Door: Designs of Integrated, Client Centered Service Plans for Persons and Families with Multiple Needs." (August, 2001), p.XI. Available online: http://www1.dshs.wa.gov/RDA/research/11/99.shtm.

[55] Louisiana Department of Social Services, "No Wrong Door: Proposal for a Reformed Department of Social Services" (March, 2004), p.9. Available online: http://www.dss.state.la.us/Documents/NWD_Final_Plan.pdf.

disability needs, but they are guaranteed a consistent and uniform response wherever they were seeking case management services.

The State of **Washington** designed one of the earliest and most comprehensive "No Wrong Door" programs for individuals and families with multiple needs and this program served as a model for other states when they developed their programs. [56] For example, in 2004, the **Louisiana** Department of Social Services released a proposal for a reformed Department of Social Services to develop a "No Wrong Door" system that was inspired by Washington's case coordination project.

The Washington model is based on a large umbrella organizational structure, the Department of Health and Social Services (DHSS), which manages and oversees programs that exist in different State departments and serve multiple populations. DHHS designed the "No Wrong Door" Case Coordination Project in 2001, and implemented a pilot program in 2002, in ten sites, at least one within each State region. In this model, a service coordinator functions as a team lead for coordinated delivery of services. The service coordinator performs and coordinates tasks such as comprehensive assessment, eligibility determination and the provision of arranging services. The service coordinator might change over time, depending on the different client needs at different points in time during the implementation of the care plan. The project focused on subgroups of clients requiring complex and expensive services from multiple DHSS programs: persons with multiple disabilities, troubled children, youth and their families and long term Temporary Assistance for Needy Families consumers.

The early implementation stage responded to barriers to integration by developing:

- A shared consent form that would allow disclosing client information across departments
- Cross-program knowledge through on-site, periodic training
- Information technology to improve communications and support document storage
- A common screening tool for multiple needs/clients
- Flexible funding across program areas

The "No Wrong Door" system has numerous implications for case management services, implications described both in the Washington and Louisiana programs. A multidisciplinary team, composed of the client's case managers from different programs, requires a broader understanding of the client's multiple needs, the services available across programs and the system's overall mechanism of action. Therefore, cross training of staff members who

[56] Washington State Department of Social and Health Services, "No Wrong Door: Designs of Integrated, Client Centered Service Plans for Persons and Families with Multiple Needs.", p.11.

participate in the multidisciplinary team is essential. The Washington Cross-Training Resolution Team recommended that team members need two types of trainings:

- General orientation and training regarding the other members' roles; legal requirements for program areas; how to monitor customer outcomes and how to use new technology
- Team-specific training regarding how to work as a team, how to develop a customer-centered care plan, how to deliver coordinated and integrated services and how to monitor outcomes.

Similar to screening and referrals, team case management is a function that requires substantial technology support, for example, an electronic case record and care plan that could be accessed simultaneously by multiple staff persons. The Washington Department of Health and Social Services developed a centralized data information system "eRoom", containing client data, status and case notes from multiple divisions. Similarly, Louisiana created a new-web based computer system, A Comprehensive Enterprise Social Services System (ACESS) that allows case workers to share case management and planning activities. A survey administered to staff participating within Washington's pilot program revealed that the software was useful for service integration. Six months after the eRoom software was installed, staff made 28 percent fewer phone calls and sent 39 percent fewer emails regarding shared clients to other team members. Emergency meetings dropped from one a month to one every six months.

Surveys of staff participating in the Washington "No Wrong Door" pilot program revealed as major achievements:

- Better coordination among staff, given that staff successfully implemented better, coordinated ways of serving shared clients.
- More complete service integration using a client-centered, strength based approach.
- Better client outcomes; staff perceived clients as being better off when services were integrated.

The implementation of a "No Wrong Door" model also represents the core feature of many long-term care state reforms. For example, the States of **Texas, Arizona, Colorado**, **New Jersey and Virginia,** among many others, received Aging and Disability Resource Center (ADRC) grants to develop "No Wrong Door" pilot programs for clients requiring long-term services.[57]

[57] The Aging and Disability Resource Centers (ADRC) grant is a joint program through the United States Department of Health and Human Services' Administration on Aging and the Centers for Medicare and Medicaid Services and is one of the President's New Freedom Initiatives to support people with disabilities of all ages to live full and independent lives. Twelve States received grants in 2003, 12 in 2004 and 19 in 2005 (Making a difference – ADRC website) 12 programs service people with all types of disability (7 serve people with disabilities of all ages and 5 serve all adults with disabilities).

The role of case managers is to clearly identify the range of services needed and preferred to support the person within the community through uniform assessments. The ultimate goal of these programs is to improve access to information and services to decrease institutionalization rates. The integration of services will ultimately lead to an improved system-wide efficiency by eliminating duplicative services and excessive paperwork.

All these programs have a strong technological component, including an online resource database and a web-based case management system. For example, Virginia uses the RTZ Associates GetCare system that incorporates a multi-agency case management tool. This tool enables pilot agencies serving the same individuals to coordinate care online by sharing assessments, care plans and progress notes. Case managers coordinate services by using detailed client information and electronic progress notes.

In 1999, **Wisconsin** started developing the Family Care Program to enhance already existing services, including information and assistance, to eliminate service duplication and to develop better access. The Care Program includes a managed long-term care benefit and developed a new single entry point system constructed around Aging and Disability Resource Centers (ADRCs). The ADRCs are units of county government and provide a full array of services to older adults and individuals with disabilities under the HCBS waiver and two integrated health and long-term care programs.[58] A 2005 independent assessment of the Family Care Program indicated:

- Wisconsin's ADRCs had improved quality of long-term care services within the pilot counties.
- The Family Care Management Organizations demonstrated strengths in care management, with case managers being creative and flexible in terms of working with the most appropriate level of services for members.
- Family Care members reported high levels of "self determination and choice" and "health and safety outcomes and supports"[59]. Members of the Family Care program

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The general mission of the ADRC grant is to streamline the eligibility process via Information and Assistance programs and to promote seamless financing of Medicaid long-term care and services dollars. This seamless financing includes the concept of "Money Follows the Person" which is when a Medicaid-funded nursing home resident move back to the community, some of his or her Medicaid funds will remain available and pay for home and community-based services. Winifred V. Quinn, "A Case Study of New Jersey Easy Access Single Entry." Rutgers Center for State Health Policy, (March 2005).

[58] The Program for All-Inclusive Care for the Elderly and the Wisconsin Partnership Program.

[59] The "self determination and choice" outcomes analyze the manner in which services are provided and health and safety outcome examine improvements in the client's overall quality of life.

saw significant reduction in institutional settings, in addition to significant reduction in limitations from impairments due to the addition of support services.[60]

- The State spent an average of $452 less per person each month for Medicaid services in four of the five counties with a managed long-term care benefit, $55 less in Milwaukee County during calendar years 2003 through 2004.

- Wisconsin's ADRCs have strong communication and formal relationships with Economic Support Units that processed Medicaid applications and the Care Management Organizations that provide services.

According to the ADRC Progress Report 2006 that evaluates the progress of the 2003 and 2004 grantees' programs, the ADRC sites have become trusted places within their communities. Contacts between customers and providers have increased with 60 percent within the sites for sites reporting in both periods.[61] Seventy-five percent of the grantees are moving toward web-based, centralized data management systems.

Lessons learned for case management services within "No Wrong Door" systems are:

- Appoint a dedicated project manager.

- Build on the expertise of existing pilot level staff.

- Cross-train staff from partnering organizations.

- Expect and plan for considerable increase in call volume and increase in average length of calls.

- Involve end-users (e.g., pilot site staff, consumers) in the entire system development process and in developing the web based system specifications.

- Monitor the impact of ADRC on case loads, as many agencies have found that case loads and phone volume increased over time. [62]

A "No Wrong Door" approach has been implemented by the Texas Department of Aging and Disability Services (DADS) in three pilot sites located in the Bexar County AAA, the Central Texas AAA and Tarant County, to streamline access and assistance in their regions for persons age 60 and over and individuals of any age with physical disabilities, mental retardation or

[60] APS Healthcare, Inc., "Family Care Independent Assessment: An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2003-2004." (October, 2005). Available online: http://dhfs.wisconsin.gov/LTCare/ResearchReports/IA.pdf.
[61] Lewin Group, "The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative: Interim Outcomes Report" (November, 2006). Available online: http://www.adrc-tae.org/documents/InterimReport.pdf.
[62] State of North Carolina, "Section 1915(b) Waiver Proposal – Piedmont Cardinal Health Plan." p. 88.

developmental disabilities. This program is funded by an ADRC grant program implemented in the second half of 2006.

This program builds on the experience of the Texas Real Choice System Change grants (discussed further below) and numerous reports recommending a single entry point, "No Wrong Door" system. State of Texas Representatives, the Texas Health and Human Services Commission staff and stakeholders have debated since late 1990s the implementation of single entry points for different target populations across the state. The Texas HHSC Long-term Care Task Force recommended in 2000 the implementation of a single point of entry, single point of connection for all long-term care services at the local level. [63] The Task Force envisioned at least one accessible site per locality at which consumers can receive access to the entire range of long-term care services. The First Regional Long-term Care Access Summit (Abilene, February 2001) defined a single access point as the community "focal point" for HHS agencies, the MHMR authority, providers and others in the community to make referrals of cases that require case management services and recommended that the single access point should provide specialty functions such as navigation services and benefits counseling.[64] The group acknowledged that requiring different organizations to share resources would be difficult.

Similarly, the Department of Aging and Disability Services (DADS) Service Delivery Design Plan identified multiple solutions to improve access and coordinate services for mental retardation, community care, nursing facilities and long-term care and aging programs. [65] The report included sub-recommendations relating directly to case management:

- Evaluate existing data, structures and reports, including cost analysis, to develop options in the provision of case management that assures equity, choice and accountability, including addressing any conflicts of interest that exits in the current system, with respect to access to programs.

- Study benefits and consequences of three case management models in Community Care, including the impact of self-determination: service provider performing case management, funding source performing case management, and independent case management.

The Texas Real Choice Grant, implemented between 2002 and 2005, responded to different stakeholders' opinions regarding promoting better coordination through a single entry point vs. multiple access point and developed a "system navigator" function at the community level using two access models:

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[63] HHSC, "Achieving Integrated Local Access and Services for the Elderly and Persons with Disabilities," (HHSC, November 2000.) Available online: http://www.hhsc.state.tx.us/pubs/IntegratedAccess112000.pdf.
[64] HHSC, "TLC-First Regional Access Summit.", (Abilene, February 2001.) Available online: http://www.hhsc.state.tx.us/hhscprojects/tlc/meeting/abilene_01.html.
[65] DADS, "Service Delivery Redesign Final Report," (DADS, April 2006.) Available online: http://www.dads.state.tx.us/news_info/publications/studies/ServiceDeliverySystemApril06.pdf.

- The Texoma Real Choice model placed system navigators at a single entry point.
- The Heart of Central Texas "No Wrong Door" model placed system navigators in ADRCs across the two regions, as well as in various agencies and organizations. [66]

The target populations for the Texas Real Choice project were consumers of all ages with disabilities and children with disabilities and/or special health care needs. The projects entailed developing and implementing training for navigators, developing and implementing common intake, referral, assessment and follow up protocols and developing methods to evaluate client and system outcomes. According to the 2005 CMS report on Real Choice grantees activities "the partnership agreements are the result of outreach and education efforts with physicians, discharge planners, and hospital administrators and will improve LTC system coordination and consumers' timely access to services".[67] The project concluded on September 30, 2005, and successfully implemented a navigator system. The navigator concept was successful at tying fragmented services and systems together.[68]

Representatives of the two projects, the Texoma Real Choice and the Heart of Central Texas, cited multiple referral systems, referral protocols and intake forms used by different service entities as a barrier to integration that should be addressed by central Information Technology and program authorities. DADS used this information to develop the ADRC grant. The three ADRC pilot sites will streamline and improve access processes including intake, eligibility, care coordination, case management and benefits coordination through the navigator function. A navigator acts 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 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 counselors) in the development of person/family-directed transition plans and arrangements for the consumers and his family. [69]

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[66] The grant referred to case managers as system navigators.
[67] U.S. Department of Health and Human Services, CMS, "Real Choice Systems Change Grants Program, Third Year Report: Progress and Challenges of 2002 and 2003 Grantees." (CMS, 2005.), p.17.
[68] DADS, "Real Choice Navigator De-briefing Summary," (DADS, March 2006.) Document submitted by Marc Gold, Manager, Promoting Independence Initiative, DADS.
[69] Texas Department of Aging and Disability Services, "Request for Proposals: Aging and Disability Resource Center Subgrants," (Texas Department of Aging and Disability Services, May 2006.) p. 20.

DADS will work with the pilot sites to implement an information management system to collect the data necessary from each site to establish whether performance goals have been reached. The ADRC pilot sites will be encouraged to consider different modifications and improvement options, including enhancements that will allow sharing of client and program data between organizations, and to determine applicability for their use locally.

C. Long-term Care Programs

The North Carolina Department of Health and Human Services, Division of Medical Assistance is also currently planning to restructure Medicaid-funded long-term services for aged, adults and child populations with disabilities, with a key focus on case management activities. The focus of the restructuring is to enhance the delivery of key HCBS and streamline core business processes, including screening, assessment, case management, utilization management and quality assurance. The overall strategy of the Division is to:

- Improve screening of recipients prior to receipt of services
- Improve assessment and case management while promoting greater recipient self-management and person-centered planning
- Upgrade provider competencies through Web based training and assistance
- Adopt a case-mix reimbursement methodology to better relate resource requirements to more predictive measures of clients' acuity levels
- Enhance utilization management and quality measurements

The State will also implement a web service that will connect the state staff with community providers and to other health and social services professionals.

Several long-term care programs have successfully integrated care coordination across multiple programs using managed care models. For example, studies of long-term care reform across states cite the Texas STAR+PLUS program as an example of a successful program for long-term services coordination.[70] Texas STAR+PLUS is a Medicaid pilot project designed to integrate acute and long-term care services through a managed care system. The program is based on a combination of 1915 (b)/(c) Medicaid waiver, which allows the provision of HCBS in a mandatory care environment. The program also aims to provide the right amount and type of service in the community based-setting consistent with the client's needs and to improve access to care and the outcomes of care. The pilot was implemented in 1998 and has served 65,600 adults as of January 1, 2005.

[70] Tennessee Disability Coalition, "Olmstead Task Force – Systems Across Country". Available online: http://www.tndisability.org/olmstead/Olmstead%20-%20Across%20the%20Country.doc.

STAR+PLUS members who require a nursing facility level of care can enroll in the statewide HCBS waiver, without being placed on a waiting list. Also, dually eligible program customers joining the Medicare and Medicaid care plans offered by the same managed care organization have enhanced drug benefits, with no limit on medically necessary prescriptions, providing an incentive for them to enroll.

Health plans are required to contact members within 30 days of enrollment, to make home visits and to perform comprehensive needs assessments and to assign a care coordinator as appropriate. Long-term services and support provided by the health plans include day activity and health services, personal attendant services and home-delivered meals. Additional services include adaptive aids, adult foster care home services, adult day care services, assisted living, emergency response services, medical supplies, minor home modifications, nursing services, respite care (short-term supervision) and therapies (occupational, physical and speech-language).

Service coordination is an integral STAR+PLUS service. Health plans coordinate all STAR+PLUS members' acute and long-term services and supports for each STAR+PLUS client who needs them.

Multiple evaluation reports showed that the program has been successful both in terms of customer satisfaction, as well as in reducing costs. According to these evaluations:

- Sixty percent of the consumers experienced no problem getting the care they need.
- Seventy seven percent were aware of a care coordinator or person to help them get services.
- Eighty percent of the consumers reported being "satisfied" or "very satisfied" with how the care coordinator explained information.
- Eighty one percent report ease in obtaining services such as personal attendants or home health services.
- The program saved $78 million annually (8 percent) over the projected costs.
- Inpatient admissions decreased by 22.8 percent.
- Emergency room visits decreased by 38.5 percent. [71]

Critics of this program have indicated, however, that the STAR+PLUS program has at times, been understaffed and there has been a lack of consistent care coordination.[72] In addition, they

[71] Texas Health Quality Alliance, "Texas Medicaid Managed Care FY 2000 Case Coordination Study Final Executive Summary" (Texas Department of Health, 2001). Lewin Group, "Actuarial Assessment of Medicaid Managed Care Options." (December 15, 2003).

noted administrative burdens due to multiple contracts and required forms, a difficult reimbursement process and an increase in administrative costs, reducing the amount of available funds for patient services.

The 79th Texas Legislature required the development and implementation of a non-capitated managed care system, the Integrated Care Management model. The Integrated Care Management model is a non-capitated, enhanced primary care case management model for aged consumers, consumers with disabilities and consumers who have blindness and visual impairments.[73] The goals of the program are to improve patient health and social outcomes, improve access to care and integrate acute and long-term care services. The program will be implemented in the Dallas and Tarrant service areas.

The HHSC Department of Aging and Disability Services is also developing different plans to reform the delivery of long-term care services. For example, the Service Delivery System Design Plan emphasizes developing consumer-focused strategies that enhance consumers' access to services easily within the local community.[74] The report recommends identifying elements for improving access to front door systems and integrating the information and referral process.

Arizona was the first state to have a capitated managed care system that combines Medicaid acute and long-term-care services. Arizona has an approved Section 1115 Waiver from CMS under which it provides services in a program called the Arizona Health Care Cost Containment System (AHCCCS). AHCCS includes an acute care program and a program for long-term care services in institutional and alternative residential settings as well as home and community-based care, the Arizona Long-Term Care System (ALTCS).

All acute care program members, whether receiving care on a fee-for-service basis or through enrollment in a managed care organization, are eligible for the same array of acute care services. All ALTCS members, whether receiving care on a fee-for-service basis or through enrollment in a managed care organization, are eligible for the same array of acute and long-term care services. The ALTCS serves aged individuals (65 and over), persons who are blind or developmentally disabled who need ongoing services at a nursing facility level of care. The program delivers Medicaid acute, long-term and behavioral health services. Health plans that participate in the Arizona program may be privately owned or operated by a county. The program contractor must assign to each member a case manager to identify, plan, coordinate, monitor and reassess the need for and provision of long-term care services. According to a CMS evaluation of ALTCS, the capitated system saved 16 percent of costs that would have been

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[72] Texas Senate Health Committee, "Report to the 77th Legislature" (The Senate of Texas, Committee on Health Services, 2000). Available online: http://www.senate.state.tx.us/75r/senate/Commit/archive/c620/pdf/c620Rep77.pdf.
[73] Texas Department of Aging and Disability Services, "Information Letter N, 07-12, Integrated Care Management Program." (April 2, 2007).
[74] Public Consulting Group, "Texas Department of Aging and Disability Services Service Delivery System Design Plan. " (April 28, 2006). Available online: http://www.dads.state.tx.us/news_info/publications/studies/sds/section1.pdf.

incurred in a more traditional Medicaid program. Another study compared Arizona's long term care expenditures to other states' expenditures and concluded that the capitated system resulted in 35 percent savings of the costs that would have been incurred without it. Both studies correlated the design of a comprehensive and careful screening process (a case management function) with the estimated savings.

D. Integrated Funding Models

New Jersey Easy Access Single Entry (NJ EASE) is a consumer-oriented statewide system that allows older adults to access HCBS. The program is the result of a partnership between the New Jersey Department of Health and Senior Services and the 21 County Offices on Aging.

The Rutgers Center for State Health Policy conducted an evaluation of this single entry point system. Researchers determined that within five different counties studied, case managers perform needs assessments, develop care plans and assist customers with the application process for services.[75] If the customer is at a nursing home level of care, they assist the customer in completing the Medicaid application. The case manager is responsible for describing the programs and services for which the client is eligible based on income eligibility and needs, maintaining monthly contact with the client and completing a reassessment every year. Researchers also noted that Atlantic County had the most integrated service system. All Atlantic County case managers are cross-trained on all waivers, assisting clients to easily switch between programs when necessary. Case managers usually perform a family assessment rather than a customer assessment.

In addition, researchers found:

- Counties where there is a seamless case management structure seem best equipped to meet New Jersey's long-term care needs.
- Seamlessness can be improved if the eligibility process were more streamlined.
- Counties with more integrated database structures and information systems have easier reporting processes, thus benefiting their external communication activities.

Among other recommendations, they suggested that the state and counties could make the information and assistance more seamless by having all case managers become familiar with all funding streams and programs so that consumers do not need to switch case managers when they move from one program to another; merging agencies that perform different tasks for the same families to decrease the overlap of services and create less disruption in the family setting; consider using the counties as the facilitators of the information and assistance system because the current system is not a true single point of entry system.

[75] Winifred V. Quinn, "A Case Study of New Jersey Easy Access Single Entry." Rutgers Center for State Health Policy, (March 2005). Available online: http://www.cshp.rutgers.edu/Downloads/6220.pdf.

Michigan's single entry point long-term care demonstration project emphasizes person-centered planning practices throughout the long-term care continuum. On October 1, 2006, four single points of entry demonstration sites opened in Detroit.

A somewhat distinct feature of this program is the consumer advisory board. Consumer participation in the creation and operation of the single entry point is required and no more than 25 percent of the membership of the Board can be a representative of direct service provider community.

Support plans for consumers must be developed through the person-centered planning process. The consumer may choose to have the supports coordinator broker his/her services or may broker his/her own services, whichever is preferred. Supports coordinators must provide face-to-face contact with consumers as least every 3 months or more frequently, as needed, when significant changes occur.

Florida has developed and implemented Resource Centers in three planning and services areas for both public and private funded services for the elderly and individuals with severe and persistent mental illness. The State had contracted with lead area agencies on aging to provide information and referral, screening and assessment, eligibility determination and options counseling. Eligibility functions are collocated with Medicaid and other state/Federal funded programs eligibility staff. According to a state representative, the ADRC model has:

- Minimized customer confusion about long-term care options.
- Enhanced individual choice
- Supported informed decision making
- Reduced services transformation
- Streamlined eligibility for services
- Improved fiscal control over public LTC resources[76]

The State uses the HelpWorks software to provide a web-based system that allows pilot sites to research client information, keep notes on clients in the system, send referrals to providers (professional edition). The system also has a public edition that allows clients to research information on services available and to create an account to save personal information in the system. Case managers identified several advantages of the professional edition:

- Provides a single information and referral system, allowing managers to share information in case of emergencies

[76] Charles T. Corley, "Taking the ADRC Statewide" (ADRC National Meeting, December 4, 2006). Available online: www.adrctae.org/tikidownload_file.php?fileId=26106&PHPSESSID=418b934ce02d0e7b5142e39b4ae68dbb.

- Produces uniform reports for each pilot site, allowing managers to track referrals and monitor services

- Facilitates communications with providers

However, pilot sites staff survey results showed that the system has several weaknesses that need to be addressed: the system's guided interview tool is not efficient enough, the system is slow and does not provide information in a useful manner and requires a VPN connection that is expensive for social services agencies. Results also indicated that the Department also needs to automate its revised intake screening tool, which includes data elements not incorporated in the current system.

An evaluation of the program's impact on consumers, including improved access to services that may delay or prevent loss of independence, is currently under way. The evaluation will also assess cost savings/avoidance associated with the delayed or avoided institutional placement and overall cost savings for the state as results of improved administrative and operational practices. The development of single point of entry for information, referrals, screening and eligibility information for long-term care services is expected to result in administrative cost savings.

III. PRIVATE SECTOR CASE MANAGEMENT MODELS

A. Case Management and Care Coordination

In the commercial sector, case management functions also vary significantly from program to program and case management functions are generally different as well. Case management is generally used to describe the close supervision a health plan or insurance company provides for chronic and particularly costly cases. Case managers work with health care providers and patients to regulate utilization when possible. Examples of costly cases include:

- Cardiovascular disease
- Cancer
- Stroke
- AIDS
- Severe traumatic injury
- Degenerative neurological disease
- Long-term psychiatric cases

Case managers are also involved in care situations of excessive duration or when such issues as patient noncompliance arise.[77] Early involvement in any potentially high-cost case is essential to achieve loss control and optimum treatment for the patient. [78]

Trained reviewers, usually nurses with extensive discharge planning experience and specialized clinical experience, monitor catastrophic cases during the acute hospitalization phase, developing a long-term treatment plan to achieve the most efficient use of medical resources and the best patient outcome.

Case management is also used within the workers compensation insurance industry and is considered to be an effective method for reducing claims costs. In Texas, the medical case manager serves as a liaison between the injured employee, the employee's healthcare provider and the State Office of Risk Management.[79]

Although managed care health plans are designed to protect against excessive losses from the types of cases that warrant the involvement of a case manager, chronic and high-risk patients

[77] John C. Garner, *Health Insurance Answer Book* (Frederick, Maryland: Panel Publishers, 2001) pp. 7-27.
[78] Studies show significant savings under medical case management. *Business and Health* reported in 1996 that the Health Insurance Association of America reported that insurance companies saved $30 for every dollar invested in case management programs. The article goes on to point out the improvements in clinical outcomes that have occurred and that are more difficult to quantify.
[79] State of Texas Office of Risk Management, *Annual Report on Cost Containment – Fiscal Year 2005*, pp.5.

still require special supervision and assistance. Case managers can be instrumental, for example, in obtaining patient approval to pursue a less costly route of treatment. Case managers can also provide patients assistance when multiple specialists and facilities are involved in the course of care.[80]

In the Institute of Medicine's *Crossing the Quality Chasm*, advocates of managed care and integration identified the essential ingredients of high-quality care: evidence-based treatment; multidisciplinary teams to provide ongoing contact and follow-up; systematic attention to patients' needs for information and behavioral change; ready access to specialists; and computerized systems, such as patient registries and automated medical records, to facilitate provider-patient communication and information-sharing among all people involved in a person's care. [81]

More recently, as case management has taken on a negative connotation in the so-called "managed care backlash," managed care and other health care providers have been implementing care coordination – optimal management of people with chronic diseases to improve outcomes and cut costs.[82]

Care coordination is much broader than classic disease management, which has historically focused on guidelines and protocols for a managing single disease (e.g., asthma, diabetes.) Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. [83] Disease management:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

Disease management components include**:**

- Population identification processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers

[80] Garner, pp.7-28.
[81] The Association of Health Care Journalists "Covering the Quality of Healthcare: A Resource Guide for Journalists." Ch.3, p.3. Available online: http://www.healthjournalism.org/qualityguide/chapter3.html.
[82] Frank Diamond, "Care Coordination Strikes Right Chord," *Managed Care* (May 2004) p. 24.
[83] Disease Management Association of America, "Definition of Disease Management." Available online at: http://www.dmaa.org/dmdefinition.asp.

- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
- Process and outcomes measurement, evaluation, and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

Traditionally, disease management focused on the "big five" chronic diseases: ischemic heart disease, diabetes, COPD, asthma and heart failure. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional and require an extended series of interactions, including a strong educational element. Patients are expected to play an active role in managing their diseases.

Because of the presence of co-morbidities or multiple conditions in most high-risk patients, this approach may become operationally difficult to execute, with patients being cared for by more than one program. Over time, the industry has moved more toward a whole person model in which all the diseases a patient has are managed by a single disease management program.

In recognition that patients often have more than one disease or health problem, disease management organizations have evolved to more patient-centric approaches that may coordinate care across several specialists.[84] Care coordination may help identify conflicting diagnoses, treatment plans or prescriptions.

Aetna has developed a program that coordinates the health services of individuals with both disabilities and health issues by integrating health and disability data. For example, Aetna's disease management programs screen people who have certain diseases for depression. If they screen positive, they are referred to their mental health/behavioral health area; if they have entered into treatment on the back end, the health plan uses the pharmacy data to make sure that dosages are adequate and their condition is being treated appropriately.[85]

Wellmark Blue Cross and Blue Shield (Iowa) initiated a program in late 2006 to provide health information to support the patient/clinical relationship; give members access to health navigation support and wellness, prevention and disease management programs and to provide information to help employers measure the correlation the programs have on productivity. According to Wellmark Blue Cross and Blue Shield, the program offers information specifically designed for clinicians, focuses on healthy members as much as on those requiring disease and case management and excels in delivering information to maximize health outcomes and productivity.[86]

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[84] Frank Diamond, "Care Coordination Strikes Right Chord," *Managed Care* (May 2004) p. 24.
[85] Diamond, "Care Coordination Strikes Right Chord."
[86] BlueCross BlueShield Association, *Wellmark Blue Cross and Blue Shield Announces Clinician-Centered, Information Support Program for Member Health Productivity* (October 17, 2006). Available online at: http://www.bcbs.com/news.

Anthem Blue Cross and Blue Shield (New Hampshire) implemented a program called Advanced Care for Advanced Diseases, an enhancement to their case management program, whereby care is delivered by nurses from the Visiting Nurse Association and Hospice Division. The intent is to better coordinate services for individuals in the last days of their lives, so they are not bounced back and forth to the hospital and between providers.[87]

Innovative program designs that reward care coordination have been suggested. One potential option is to structure payment based on the total care of a patient during an acute episode or over a period of time.[88] The incentive payments would increase accountability for a patient whose care is dispersed over several physicians and specialties. It is believes that longitudinal coordination of care for patients with multiple chronic diseases, (e.g., patients who have diabetes, chronic pulmonary obstructive disease and congestive heart failure) may result in reduced hospitalizations, better management of chronic disease, improved outcomes and cost savings.

B. Consumer-Driven Approach

In a shift over the past few years, commercial health care purchasers are increasingly moving towards consumer-directed health plans, as an approach to managing costs and maintaining quality.[89] Consumer-directed health plans encourage consumers to become better health care purchasers by placing more responsibility on them for directing their health care services.

Educating patients and providing tools to help manage health is central to the concept of consumer-directed health care. Many use disease management, wellness programs and other care management programs to involve consumers in their health care decisions. Most disease management programs are directed at diabetes, asthma and cardiovascular disease, while wellness programs provide incentives for health-promoting behavior (e.g., fitness or smoking cessation) that may reduces health care costs.

In Medicaid and public programs, consumer direction of services is often a component of a philosophy of self-determination, in which individuals with disabilities have greater control over their lives, including health care decisions. In Texas HHSC consumer-directed services programs, the consumer can make informed choices regarding hiring, firing, managing, training and supervising attendants and in some cases respite providers staff, as well as directly purchase services.

Texas was one of the first states to receive approval from CMS for the implementation of consumer-directed services in multiple Medicaid HCBS waiver programs and in the Medicaid

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[87] Anthem Blue Cross Blue Shield of New Hampshire, *Promoting Excellence in End-of-Life-Care* (June 14, 2001). Available online at http://www.promotingexcellence.org.

[88] Karen Davis, "Paying for Care Episodes and Care Coordination," *New England Journal of Medicine* (March 15, 2007) 365(11):pp. 1166-1168.

[89] Deloitte, *Reducing Corporate Health Care Costs 2006 Survey* (2006).

State Plan. Currently, several DADS and HHSC programs offer consumer-directed services options, including:

- Community Based Alternatives (CBA)
- Community Living Assistance and Support Services (CLASS)
- Deaf-Blind-Multiple Disability Waiver (DBMD)
- Client Managed Personal Assistance Services (CMPAS)
- Medically Dependent Children's Program (MDCP)
- Primary Home Care (PHC)
- STAR+PLUS

In Texas, the HHSC developed additional initiatives to enhance consumer-driven services. For example, parents of children with disabilities provide case management to other parents and individuals with disabilities provide peer support within Independent Living Centers. The case management services for young people with disabilities and individuals relocating from nursing facilities are also consumer-driven.

IV. CONCLUSION

This report has defined and identified case management models used by other states and the commercial sector. Case management systems are continuing to evolve, providing case studies for consideration in Texas.

Of relevance to this study, case management definitions and functions vary across programs as a function of program goals, the population served or the required provider qualifications. This variation is ubiquitous in state case management systems; therefore, we could find no reference to a state that developed a single definition of case management or a standardized qualification system for service providers. Nonetheless, in order to enhance access to services and to reduce service duplication and system inefficiencies, many states designed micro-consolidation programs that integrate case management functions for multiple populations. Single entry point systems, "No Wrong Door" programs, integrated long-term care programs and integrated funding models are all facets of this trend.

States operate single entry point systems to enable consumers to access services through one agency or organization. Most of the single entry point systems serve two or more populations, perform a wide array of functions and employ multiple funding sources. Single entry points frequently target older adults, people with disabilities, people with MR/DD and people with mental health issues. In terms of the populations served, states tend to develop a single entry point system for older adults and adults with disabilities and parallel systems for persons with mental retardation and developmental disabilities and mental health issues, to best address the specific needs of these populations.

"No Wrong Door" programs further integrate the delivery of services for multiple target populations regardless of a person's disability and different needs. Regardless of where a client enters the system, case management services are designed to address any need and facilitate easy access to services.

The ADRC grants, currently implemented in forty-three states and territories, pilot the development of "No Wrong Door" systems for multiple populations based on these key emerging trends. Twenty pilot ADRC sites in ten states serve people with all types of disabilities, although they tend to develop processes and tools tailored differently for children and adults. These pilots will provide key insight on strategies to integrate services for populations with fundamentally different needs.

Even within the previously described approaches, e.g., single entry point, "No Wrong Door", integrated funding and others, there is considerable blending of concepts. Our analysis shows that some states prefer developing simultaneously "No Wrong Door" systems for populations with similar needs and single entry point systems for populations requiring highly specialized services.

Although currently more prevalent within the commercial sector, care management and care coordination are emerging as quality and cost control measures implemented with respect to the Medicaid program. Most often, states modify and expand case management functions to integrate care management and coordination.