Texas Health and Human Services Commission

Case Management Optimization

RECOMMENDATIONS FOR IMPROVING TEXAS CASE MANAGEMENT DELIVERY

NAVIGANT
CONSULTING

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Appendices

EXECUTIVE SUMMARY

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

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

This report responds to Section 2.4.1.3 of the HHSC RFP, which indicates that the contractor will provide recommendations for improving the delivery of case management services in Texas.

We based the recommendations in this report on our professional experience, our findings related to our analysis of the current case management system in Texas, our research into best practices and emerging trends in case management and stakeholder input obtained through focus groups, interviews and surveys. Key findings from our analysis of the current case management system from which we based the recommendations in this report include:

- *Definitions of Case Management* – Many of the case management programs we reviewed define case management services differently. Programs may also refer to case management services as case management, care coordination, service coordination or care management. There is considerable variation in qualification requirements for case managers across programs.
- *Reimbursement, Funding and Utilization* – The lack of uniform data creates difficulty in comparing utilization, consumers of case management services and expenditures across programs. Additionally, as described in the *Case Management Optimization, Analysis of the Current Case Management System Report*, there is no common reimbursement methodology for case management services across the HHSC enterprise. Case management is paid as a separate service, as part of bundled program rates or through administrative claiming. Finally, case management programs for which payments are made on a monthly basis may encourage case

managers to schedule visits with their consumers at the end of the month, regardless of whether the consumer may require a visit, so that the case manager can bill for the monthly case management payment.

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

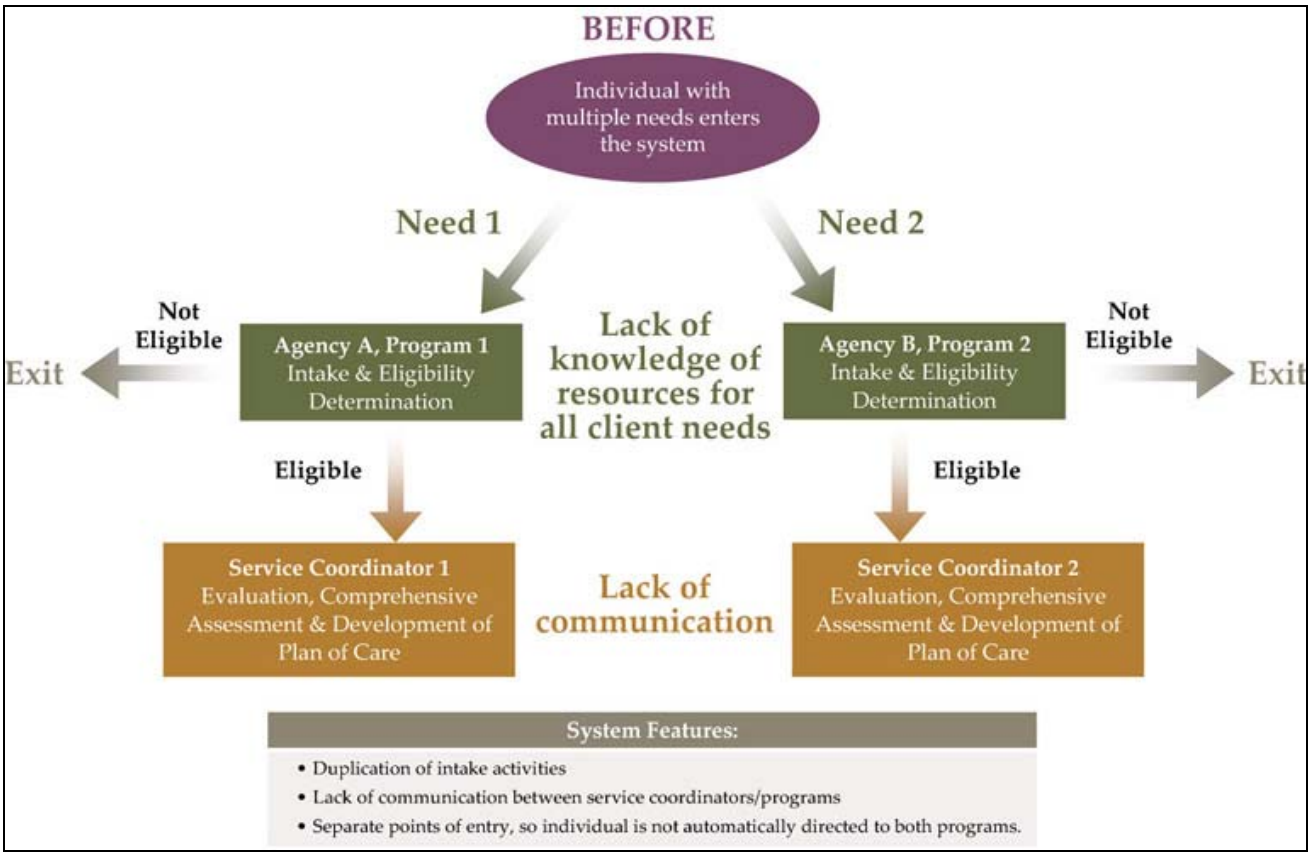
- *Coordination and Knowledge Sharing Between Programs* – Based on the design and function of the case management program, the level of coordination between programs, departments and other organizations varies widely. Additionally, some stakeholders have raised concerns about case managers not knowing what resources are available for their consumers and the need for the consumer, family member or guardian to educate the case managers about the needs of the consumer.

- *Geographic Issues* – Although there appear to be issues regarding the delivery of case management services specific to rural areas of the state related to supply of case management professionals, in general, geographic issues appear to primarily impact the services that case managers authorize for their consumers.

- *Administrative Issues* – It appears that direct service duplication is minimal; however, programs may be duplicating intake, eligibility and referral efforts. Many programs perform these "front door" functions separately. Our review has shown that there is no common tool used to make essential case management decisions, such as screening, initial assessment, triage, service linkage and monitoring/oversight. In fact, based on our review of the current system and interviews with consumers, case managers and state program managers, the intake process is where we identified the most duplication of efforts, especially in screening, assessment for appropriate services, and in service linkages.

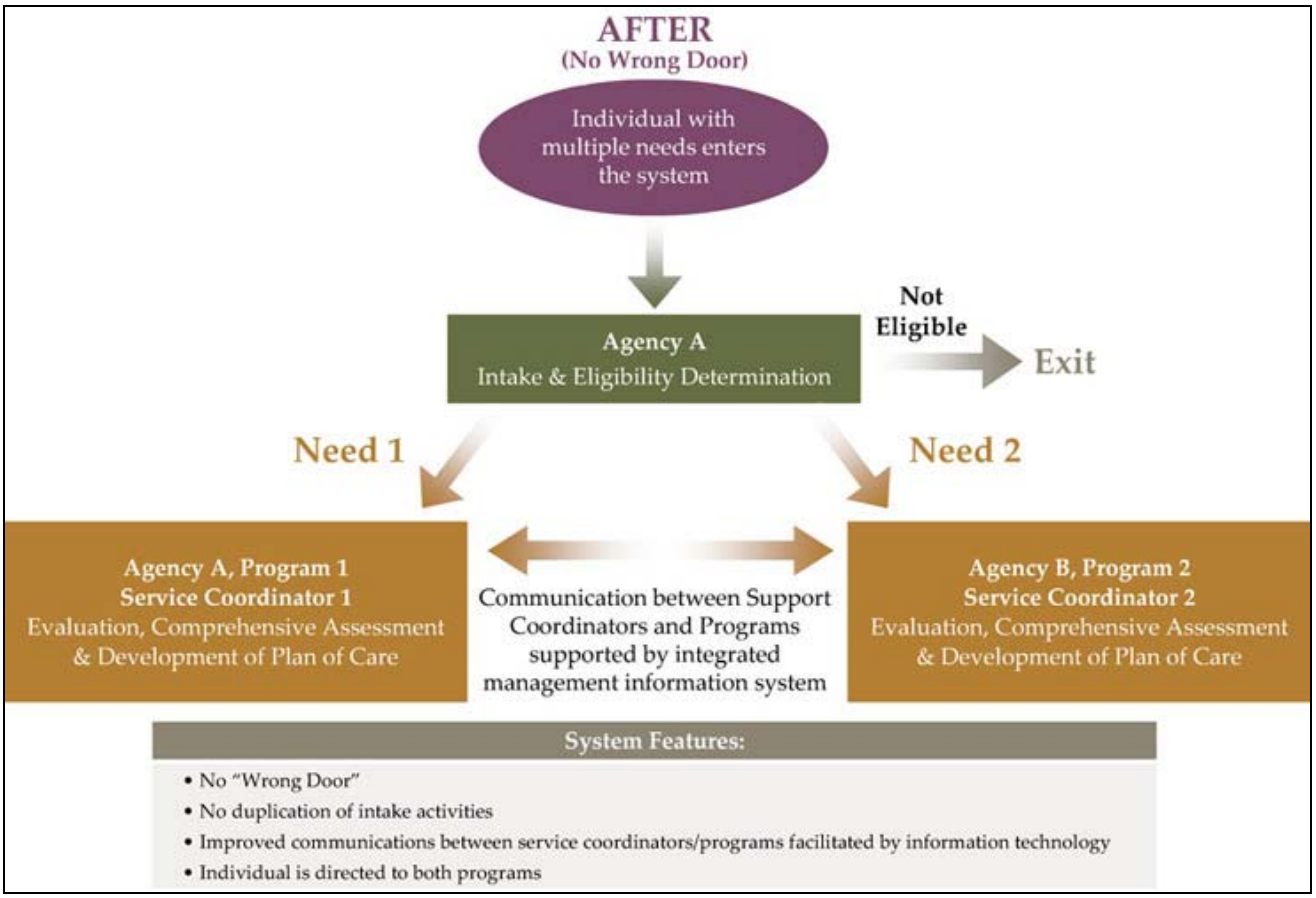
As a result, the current system creates an environment where an individual may access the system at different points for different needs (and may not have all needs addressed by the same entity, resulting in an unmet need), may encounter duplicative intake processes and may be involved with multiple case managers who lack sufficient tools to coordinate and communicate with each other, as illustrated in the Figure 1 on the following page. This figure displays the pathway of an individual's entry into Texas's current case management system. Specifically, the figure shows how an individual with multiple needs enters the system through two different entry points (agencies) for two different needs. In this example, it is possible that if the individual does not know about both agencies or if one of the agencies does not have the knowledge to refer the individual to the other agency, all of the individual's needs might not be met. Additionally, the individual may encounter duplicative intake processes for both programs (one at each agency) and may have two case managers who lack sufficient tools to coordinate and communicate with each other.

Figure 1: Current System



In an "optimized" case management system, as illustrated in Figure 2 on the following page, there is "no wrong door" for a consumer to access services; a single intake and screening process would determine the most appropriate programs available to the individual and case managers and programs would have the necessary tools to communicate with each other about an individual. This figure displays the pathway of an individual's entry into a system with a "no wrong door" approach. An individual with multiple needs enters the system through one entry point; a single intake and screening process at the entry point determines the most appropriate programs available at the different agencies for the individual, and directs the individual to these programs. The case managers and programs have the necessary tools (i.e., an integrated management information system) to communicate with each other about the individual.

Figure 2: Optimized Case Management System



Primary Recommendations

The following are key recommendations which provide the basis for optimizing case management services in Texas and address our major finding from our review of the current case management system.

1. **Develop a common baseline service definition for "case management" across the systems included in the Optimized Case Management Project and consider changing the term "case management" to "service coordination."**

   We recommend that HHSC develop a common service definition of case management that is applicable to all the systems under review; this common service definition should serve as the basis for optimizing case management services and would serve as the foundation for many of the recommendations we make in this report. Concurrently, we recommend that the term "case management" be replaced with "service coordination" to be in sync with the optimization strategies we are recommending below.

2. **Develop guidelines for a tiered qualification system and caseloads for case managers that link case manager qualifications to the consumer's need for levels of intensity and specialized interventions.**

   We recommend HHSC develop guidelines for a tiered approach to case manager qualifications and caseloads, recognizing the need for advanced qualifications for more intensive case management for consumers with special needs.

3. **Develop a uniform protocol for initial screening, triage, referral (and authorization where applicable) as a basic tool to carry out improved case management responsibilities and reduce inefficiency and ineffectiveness in the system**.

   A common protocol for screening, triage, referral (and authorization, where applicable) could enhance quality and reduce costs through the reduction of duplication of efforts, and improve communication and coordination among different service entities, including service systems that are not part of the optimization project, such as the STAR+PLUS Program. A common initial screening, triage and referral protocol would be most beneficial for consumers with multiple needs, as they would obtain reliable referral information for different services and agencies at their first contact with the system.

4. **Integrate management information systems across the various departments to facilitate the sharing of data between departments and to standardize the collection and reporting of appropriate data for tracking and monitoring financial performance and outcomes measures.**

   The development of an integrated management information system for case management services would help to address many of these issues and enhance the ability of HHSC to monitor program quality and manage utilization. An integrated system would allow HHSC to standardize outcomes and financial data and reports across all programs to support the ongoing monitoring and evaluation of case management services. The financial metrics would focus primarily on key cost-related metrics such as per consumer cost and utilization and would allow the state to independently measure the performance of the case management program on a quarterly basis. The system would also serve as a centralized warehouse for consumer and provider information and incorporate tools to enhance the ability of case managers to meet the needs of their consumers. The development of an integrated management information system across the various departments and programs is critical to accomplishing these goals.

5. **Develop a uniform reimbursement methodology.**

   Reimbursement for case management services should be based on a consistent methodology across the HHSC enterprise and should be a unit-based method that reflects the amount of service being provided by the case manager, with reimbursement reflecting both the amount and intensity of services. It is desirable for unit definitions to be consistent (e.g., 15-minute increments). The new methodology would be built upon the case management definition and qualifications developed as part of Recommendations 1 and 2.

Recommendations for Integrating Case Management Services

The second set of recommendations focuses on how the state can begin to undertake integration of case management services, while advancing a consumer-centered approach, through the statewide expansion of the single entry point and no wrong door delivery models and the implementation of a centralized system for administering case management services.

1. **Undertake a statewide expansion of the no wrong door delivery model to integrate case management services.**

   We recommend HHSC integrate case management through the statewide expansion of the no wrong door delivery model. HHSC would expand integrated case management for adults and children with single- and multi-system needs through the development of a no wrong door system incorporating features and lessons learned from the Aging and Disability Resource Center (ADRC) pilot program as well as the Community Resource Coordination Group (CRCG) program now underway in Texas While we recognize that the development of the no wrong door model is not limited to case management services and typically involves the full continuum of services, the focus of this recommendation is to use this model as a way to expand integrated case management for children and adults statewide.

2. **Develop a cooperative approach to administering the expansion of integrated case management services.**

   HHSC should manage the implementation and ongoing administration of the single entry point system in a way that targets improved productivity and/or cost savings. We recommend looking at other transformation efforts at HHSC and at the private sector to model an approach for managing the case management optimization efforts in a way to support both better outcomes for consumers and higher efficiency in performing case management. For example, given HHSC's recent success with in-house consolidation projects, we recommend that HHSC initiate an agency cooperative/consensus-built effort to craft a case management delivery system to meet its goals. This effort should build its system based upon developing a plan

using "most efficient organization" and/or public/private partnership models. Agencies currently housing case management functions would continue to provide administrative support and HHSC would shift case management resources from each agency currently operating these functions to the unit that would perform the new case management.

Potential Barriers and Implementation Risks

Each of these recommendations requires careful deliberation of existing constraints and risks for implementation. Potential barriers and implementation risks related to the recommendations for optimizing the case management delivery system in Texas include:

- *Regulatory Constraints* – Many of these recommendations are constrained by state and federal regulatory requirements. For example, while the definition of case management varies for case management services funded by Medicaid, it is important to note that Medicaid regulations regarding coverage, funding and payment play an important (and restrictive) role in how case management is defined and programs are designed. Additionally, state and federal privacy regulations would affect the design and functionality of an integrated information system.

- *Legal Constraints* – Changes in definitions, terminology and reimbursement methodology related to case management services provided through the Department of State Health Services Children and Pregnant Women program must be in compliance with the Frew v. Hawkins consent decree and associated corrective action plan.

- *State Plan and Waiver Changes* – Changes in definitions, terminology and reimbursement methodology for case management funded by Medicaid would require amendments to the Medicaid State Plan and waiver programs. By amending the Medicaid State Plan and 1915(c) Medicaid waivers to modify service definitions, HHSC would open the entire case management program and waivers to federal scrutiny, including components that the state may not want to change.

- *Changes to State Rules and Regulations for Non-Medicaid Services* – Changes in definitions, terminology and reimbursement methodology for case management funded from non-Medicaid sources (e.g., the Children with Special Health Care Needs program) would also require changes to state rules and regulations pertaining to those programs.

- *Technological Requirements* – Technological changes are critical to the successful implementation of these recommendations and require significant planning and resource allocation. The changes would require significant modifications to billing and payment systems as well as provider training on the new billing process.

- *Existing Culture* – Many service systems, owing to long tradition and practice patterns, may not welcome significant changes in the case management system, whatever they may be, and so constant dialogue, involvement and communications with stakeholders would be critical to changing the case management system.

- *Funding* – Additionally, funding for these recommendations will depend on approval from the State Legislature.

Overarching Implementation Considerations

It is not necessary for HHSC to take an "all or nothing" approach to implementing the recommendations discussed in this report. Rather, HHSC could choose to selectively target changes to programs that impact the greatest number of consumers. Additionally, HHSC could decide to phase in recommendations, starting with those that lay the foundation for larger system changes. For example, developing a common service definition and provider qualifications guidelines would facilitate the development and implementation of a common reimbursement methodology or developing an integrated management information system and integrating case management services.

Additional details regarding each recommendation, including implementation steps and cost and savings estimates are provided in the detailed report.

SECTION I: INTRODUCTION

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

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We based the recommendations in this report on our professional experience, our findings related to our analysis of the current case management system in Texas and our research into best practices and emerging trends in case management and stakeholder input obtained through focus groups, interviews and surveys. Our findings regarding the current case management system are summarized below and are detailed in the *Case Management Optimization, Analysis of Current Case Management System Report.* We understand that over the years the state has performed a number of studies of the case management system and, in general, our findings and recommendations generally agree with some of the recommendations in these reports.[1] Our analysis indicated that HHSC programs provide a wide range of case management services to different target populations through multiple access points. While consumers do have access to services, these parallel delivery systems may be creating some

[1] Previous studies of case management in Texas include the November 2000 HHSC report, *Achieving Integrated Local Access and Services for the Elderly and Persons with Disabilities*, and the HHSC report, *A Report to the Governor and the 80th Legislature on the Community Resource Coordination Groups of Texas, Fiscal Years 2005 and 2006.* In the past, fiscal and/or political considerations may have delayed the implementation of the recommendations included in these reports.

administrative inefficiencies and contribute to less than optimal service delivery for certain individuals.

Key findings from our analysis of the current case management system from which we based the recommendations in this report include:

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

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

  Some services are unique to one program. For example, case management, provided as a part of guardianship services in the Department of Aging and Disability Services (DADS) Guardianship Program, is conducted within the general duties and responsibilities as outlined in the specific Order of the Court.[2] These responsibilities may include managing the wards' estates if appointed as guardian of the estate and making medical decisions about major events such as surgery and life-threatening illness, if appointed as guardian of the person.

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

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

Additionally, the duration and intensity of case management varies among programs. Some programs offer more intense and ongoing services, based on the needs of their consumers; other programs may provide case management services mainly during the enrollment or eligibility process, only during transition to a different level of care or only during a defined time period.

For example:

- The Deaf/Blind with Multiple Disabilities (DBMD) program serves a small, high-needs population. Case managers for the DBMD program not only assist consumers with enrollment and eligibility, they also plan, coordinate (and sometimes provide) consumer services, and advocate on behalf of their consumers.

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

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

- The Department of Family Protective Services (DFPS) Adult Protective Services (APS) program provides case management only during the period of investigation and service delivery.

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

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

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

  - There is no common reimbursement methodology for case management services, even within the same program. The state pays for case management services using a variety of methodologies. Within the same program, there may be several funding streams that each use a separate reimbursement methodology. In the Early Childhood Intervention (ECI) program, for example, contractors providing Medicaid Targeted Case Management submit

claims that are paid by Medicaid; costs for non-Medicaid consumers are paid through a contracted amount and include federal non-Medicaid funding sources like the Individuals with Disabilities Education Act (IDEA) and Temporary Assistance for Needy Families (TANF) federal grants, as well as state general revenue.

- Average payments per consumer vary widely.

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

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

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

Finally, case management programs for which payments are made on a monthly basis may encourage case managers to schedule visits with their consumers at the end of the month, regardless of whether the consumer may require a visit, so that the case manager can bill for the monthly case management payment.

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

  - Caseloads vary across programs from seven in the Adult Protective Services (APS) Facility Investigations program to several hundred in the CBA and Community Care for the Aged and Disabled (CCAD) programs. Some programs are not able to determine caseloads or leave caseloads up to the discretion of a contracted case management provider or to state-employed staff.

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

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

  - A case manager for the Department of State Health Services Children and Pregnant Women (CPW) program, which includes state staff and contracted enrolled providers, must be either a currently licensed registered nurse or social worker.

  - In several other programs, including the DADS Home-and Community-based Services (HCS) program, case managers are required to have graduated from high school and have at least two years of work experience in social, behavioral or human services.

  - Some programs that use contracted providers for case management functions do not specify qualification requirements for case managers. For example, the state does not specify case manager requirements for Aging and Disability Resource Centers (ADRCs) or Area Agencies on Aging (AAAs).

- *Coordination and Knowledge Sharing Between Programs* – Based on the design and function of the case management program, the level of coordination between programs, departments and other organizations varies widely. For example, preliminary results of a voluntary case management provider survey (conducted on-line and through a mail-in survey) indicated that approximately two-thirds of survey participants indicated that insufficient coordination across agencies is a major or moderate problem within the case management system in Texas.[3] State staff reported during targeted interviews that effective data sharing among HHSC departments and programs is an issue. A number of departments and programs reported in targeted interviews and focus groups that case managers do not have the information they need about other services that consumers are receiving. Others reported that they rely on self-reported data from consumers. Some case managers expressed concern that consumers would encounter a "wrong door" and subsequently be turned away for services. Additionally, some stakeholders have raised concerns about case managers not knowing what resources are available for their consumers and the need for the consumer, family member or guardian to educate the case manager about the needs of the consumer.

- *Geographic Issues* – Although there appear to be issues regarding the delivery of case management services specific to rural areas of the state related to supply of case

[3] Approximately 245 individuals participated in the survey.

management professionals, in general, geographic issues appear to primarily impact the services that case managers authorize for their consumers. For example, feedback from consumer focus groups identified concerns that there are fewer social services and options available in the Valley region as compared to in other parts of Texas. Other consumers indicated concerns regarding transportation costs in rural areas and difficulty accessing services in general in those areas. Feedback from focus groups with case management staff indicated difficulties obtaining necessary services for consumers in rural areas. They also indicated that as a result of a scarcity of services in those areas, case managers often provide more direct care services and establish a close working relationship with consumers.

- *Administrative Issues* – One of the areas of focus of this study is the extent to which consumers have multiple case managers and the effect that this has on consumers. The results of the consumer survey indicate that the percentage of consumers who had multiple case managers at the same time decreased considerably since those consumers started receiving services. About 27 percent of consumers currently have more that one case manager compared with 46.5 percent who had multiple case managers at the time since they started receiving services. The reduction in the percentage of consumers with multiple case managers is evident across all departments.

  In both focus groups and surveys, consumers and case managers reported similar attitudes toward having multiple case managers, i.e., having more than one case manager is not necessarily viewed negatively by consumers and case managers. Consumers and case managers are both concerned, however, about duplication in the areas of intake and assessment.

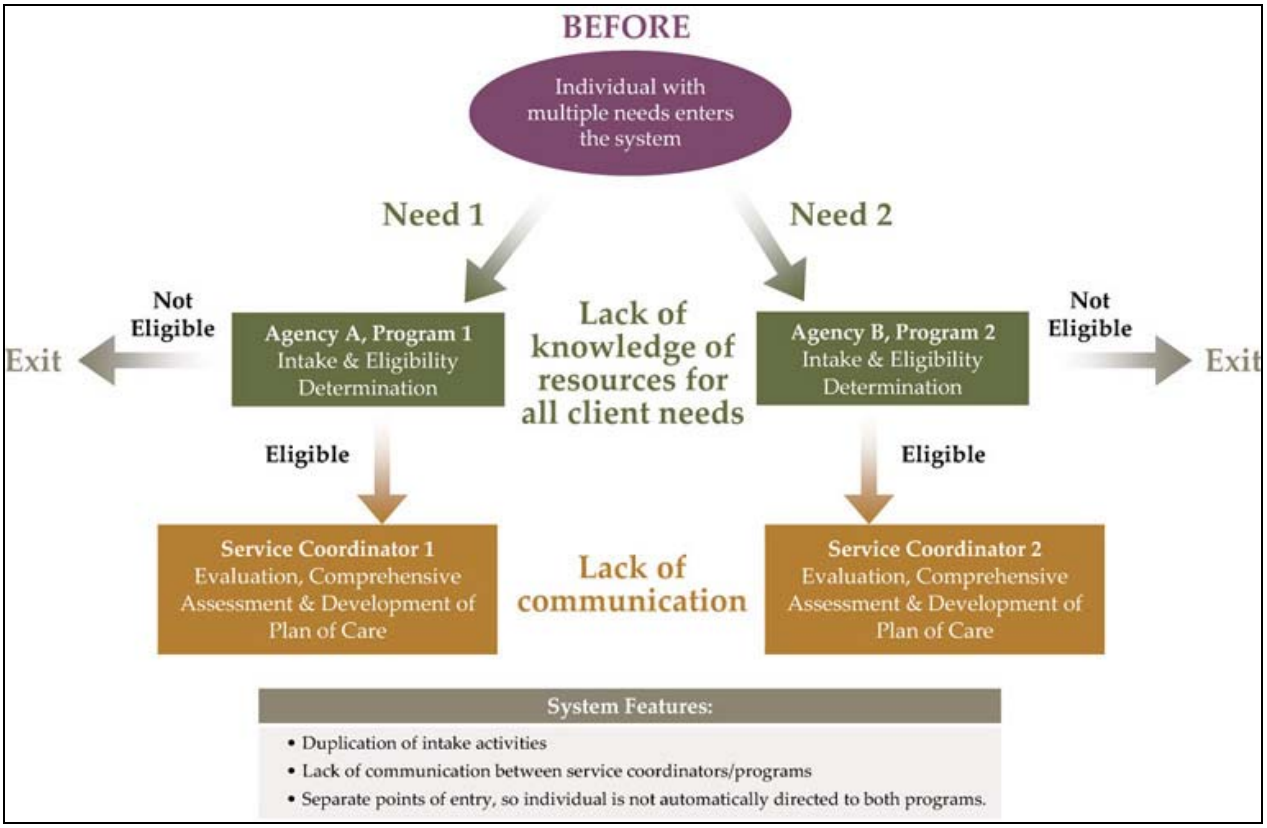
  The results from the consumer and stakeholder groups and survey are mixed in terms of the effect that having multiple case managers has on consumers. For example, the majority of consumers surveyed did not indicate that having multiple case managers created difficulties for them. However, several focus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

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

because case management services provided by different systems (e.g., behavioral health and aging and disability) are different in focus.

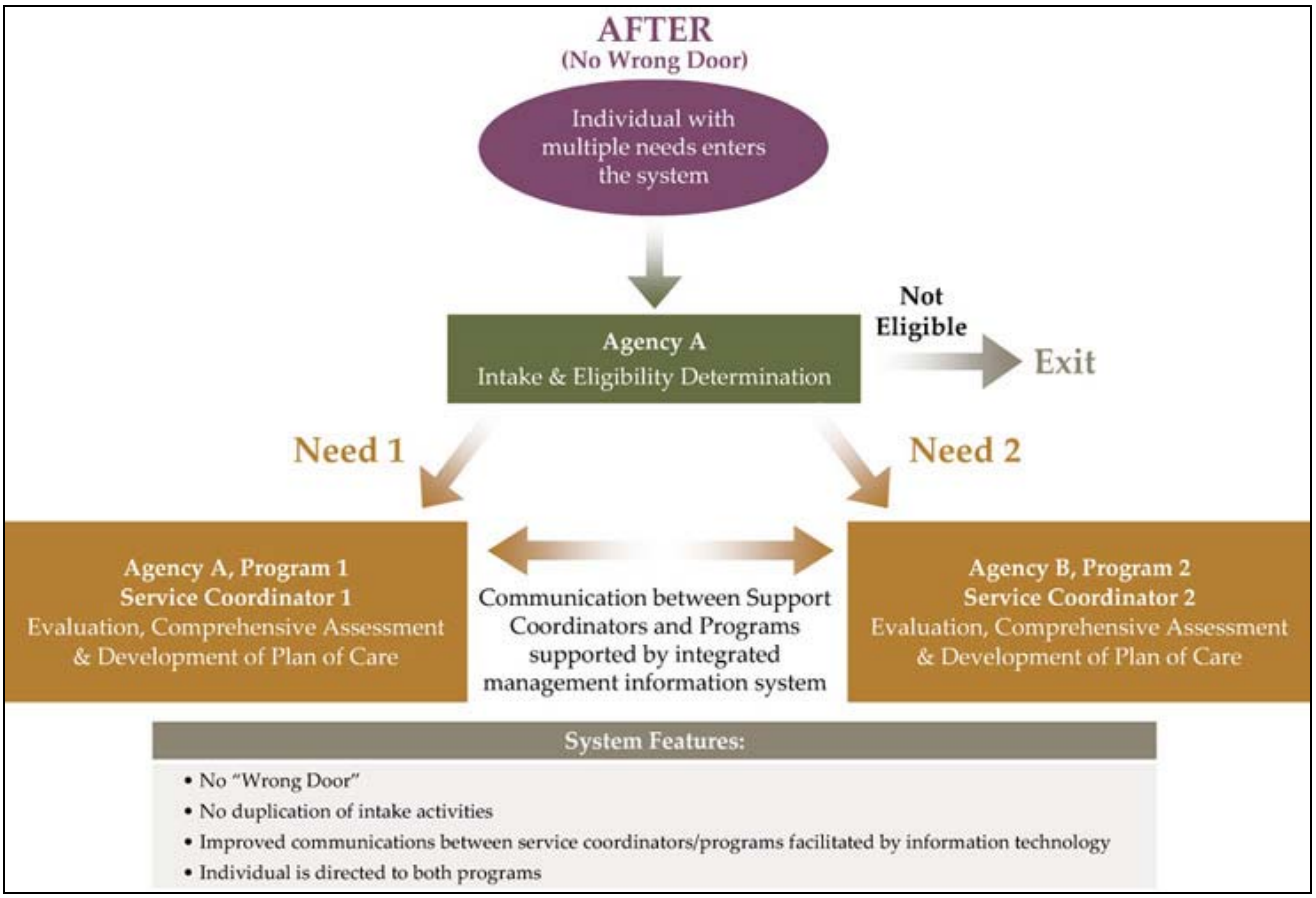
As a result, the current system creates an environment where an individual may access the system at different points for different needs (and may not have both needs addressed by the same entity, resulting in an unmet need), may encounter duplicative intake processes and may be involved with multiple case managers who lack sufficient tools to coordinate and communicate with each other, as illustrated in the following Figure 1.1. This figure displays the pathway of an individual's entry into Texas's current case management system. Specifically, the figure shows how an individual with multiple needs enters the system through two different entry points (agencies) for two different needs. In this example, it is possible that if the individual does not know about both agencies or if one of the agencies does not have the knowledge to refer the individual to the other agency, all of the individual's needs might not be met. Additionally, the individual may encounter duplicative intake processes for both programs (one at each agency) and may have two case managers who lack sufficient tools to coordinate and communicate with each other.

Figure 1.1: Current System



In an "optimized" case management system, as illustrated in Figure 1.2, there is "no wrong door" for a consumer to access services, a single intake and screening process would determine the most appropriate programs available to the individual and case managers and programs would have the necessary tools to communicate with each other about an individual. This figure displays the pathway of an individual's entry into a system with a "no wrong door" approach. An individual with multiple needs enters the system through one entry point; a single intake and screening process at the entry point determines the most appropriate programs available at the different agencies for the individual, and directs the individual to these programs. The case managers and programs have the necessary tools (i.e., an integrated management information system) to communicate with each other about the individual.

Figure 1.2: Optimized Case Management System



The recommendations outlined in this report are designed to support the system-wide transition to an "optimized" case management system with an emphasis on improving the quality of case management services.

We also based our recommendations on our key findings related to best practices in case management which are detailed in the *Case Management Optimization, Best Practices and Emerging Trends in Case Management Report*. One of our primary findings in that report is that 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 delivery system entry points. In recent years, the Centers for Medicare and Medicaid Services (CMS) has been working to better meld programs, including case management, across populations. This trend may be seen in the development of:

- Single entry point systems that enhance case management to a specific population and/or across populations.

- "No Wrong Door" programs which also provide a single entry port, and 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.

- Long-term care programs with features such as more emphasis on integrated case management activities and greater reliance on technology and administrative efficiencies.

- Integrated funding models include ADRC and "money-follows-the-person" grants, which 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. Texas recently implemented three ADRC pilot programs. In Texas, integrated funding also includes the implementation of the Texas Integrated Funding Initiative (TIFI) sites, which the state developed as systems of care in local communities for children with severe emotional disturbances, and their families, by integrating federal, state, and local funds and other resources. One of the stated goals of the TIFI Program is to support communities in managing funds and providers through a single local entity to produce better outcomes for children and their families. According to a January 2005 report issued by the TIFI Consortium, "TIFI has demonstrated an efficient service delivery approach for children/youth with complex mental health needs and their families that is strength-based, child centered, family-focused, has community-based management and decision-making responsibility, and has programs and services that are responsive to the cultural, racial and ethnic differences within the communities."[4]

Our findings from our assessment of Texas' current case management system, our research of best practices and stakeholder input obtained through focus groups, interviews and surveys provided the foundation for developing our recommendations, which are discussed in the following section.

[4] The State of Texas Integrated Funding Initiative Consortium, *Report to the Governor and 79th Legislature Systems Of Care For Children With Severe Emotional Disturbances And Their Families* (January 2005), p. 9.

We have structured the remainder of this report as follows:

- *Section II* – Provides a discussion of the criteria we used in developing the recommendations.
- *Section III* – Provides details on our "primary" recommendations which provide the basis for optimizing case management services in Texas and addressing our major findings from our review of the current case management system.
- *Section IV* – Provides options for implementing the primary recommendations, including a discussion of options for changing the State Plan and Rules and amending waiver programs.
- *Section V* – Provides details of our recommendations for integrating case management services in Texas which include strategies for expanding single entry point and no wrong door systems and centralizing the administration of case management services across the HHSC enterprise.
- *Section VI* – Provides a summary of the estimated costs and savings associated with the implementation of the recommendations.
- *Section VII* – Provides our conclusions.

SECTION II: CRITERIA FOR EVALUATION OF RECOMMENDATIONS

Prior to developing recommendations, Navigant Consulting developed a list of criteria that each proposed recommendation should meet. The criteria were designed to focus the development of our recommendations so that they are in line with the goals of Senate Bill 1188, are feasible from regulatory and financial standpoints, are evolutionary and not revolutionary and considered best practices where possible. Proposed recommendations should meet each of the following criteria:

- The recommendations should be in line with the goals for the case management optimization efforts as described in Senate Bill 1188, including:
  - 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

  We provide a crosswalk of each recommendation to the goals of Senate Bill 1188 in Table 3.16 at the end of Section III and Table 5.6 at the end of Section V.

- The recommendations should be feasible from regulatory, financial and operational standpoints.

- The recommendations should be evolutionary, not revolutionary so as to not create major disruptions in service delivery. The recommendations should be transformative in nature and should result in overall enterprise-wide improvements in program efficiency and cost-effectiveness.

- Where possible, recommendations should consider best practices, whether from within Texas or from other states, which should be tailored to the specific needs of Texas.

- Where possible, recommendations should make use of existing resources. However, within recommendations, we will establish priorities in areas requiring new resources as additional funding becomes available.

Our recommendations follow and are categorized into the following three sections:

- *Primary Recommendations* – These recommendations provide the basis for optimizing case management services in Texas and address our major findings from our review of the current case management system.

- *Implementation Options* – This section outlines potential options for implementing the primary recommendations.

- *Recommendations for Integrating Case Management Services* – This section provides recommendations for how the state can begin to undertake integration of case management services, while advancing a consumer-centered approach.

SECTION III: PRIMARY RECOMMENDATIONS

The following are key recommendations which provide the basis for optimizing case management services in Texas and address our major findings from our review of the current case management system. A number of these recommendations echo recommendations made in numerous studies and reports going back several years, including the November 2000 HHSC report, *Achieving Integrated Local Access and Services for the Elderly and Persons with Disabilities*, and the HHSC report, *A Report to the Governor and the 80th Legislature on the Community Resource Coordination Groups of Texas, Fiscal Years 2005 and 2006.*[5] It is not necessary that HHSC implement all recommendations for all departments. Rather, HHSC has flexibility in how it chooses to implement the recommendations and could, for example, decide to selectively implement recommendations to impact the greatest number of consumer, or consider phasing in the recommendations to lay the foundation for future changes.

Overview

Each of the five recommendations is comprised of the following sections:

- *Overview* – A general description of the recommendation
- *Rationale* – A discussion of the rationale for the recommendation, including the advantages of implementing the recommendation
- *Potential Barriers and Implementation Risks* – A description of potential barriers and risks related to implementing the recommendation
- *Implementation Plan* – A description of key tasks required to implement the recommendation
- *Cost Estimate* – A discussion of the estimated costs associated with the recommendation

The recommendations impact programs using various funding streams, including Medicaid, Title IV-E, state general revenue, etc. and identify potential risks and considerations in terms of how these funding streams may affect the ability of the state to implement the recommendation.

[5] In the past, fiscal and/or political considerations may have delayed the implementation of the recommendations included in these reports.

Recommendation #1

Develop a common baseline service definition for "case management" across the systems included in the Optimized Case Management Project and consider changing the term "case management" to "service coordination."

Overview

We recommend that HHSC develop a common service definition of case management that is applicable to all the systems under review. Based on our study of the current case management programs in Texas and the evolution of case management practices in the public aging, disabilities and behavioral health systems, there are sufficient common features to move in this direction. Common terminology should serve as the basis for optimizing case management services and would serve as the foundation for many of the recommendations to follow, including developing standard case manager qualifications; a uniform reimbursement methodology; a uniform screening, triage and referral protocol and an integrated information system. This recommendation is designed to develop a "baseline" definition of case management that would serve as the common foundation for how case management is defined across departments and programs. Because of the unique attributes of the various programs and the populations each serves, it is expected that each program would build upon the baseline definition to reflect the specific needs of the program.

HHSC has already undertaken efforts to develop a common definition for case management services through the work of the HHSC Case Management Optimization Workgroup, consisting of representatives from departments and programs across the HHSC enterprise, which developed the common definition provided in Figure 3.1 on the following page. HHSC should build upon the efforts of the workgroup by using this definition as a starting point for developing the common definition.

Concurrently, we recommend that the term "case management" be replaced with "service coordination" to be consistent with the optimization strategies we are recommending below. Case management has had a long history in most services systems and is inevitably affected by practice tradition and force of habits that may interfere with the policy direction to promote coordinated or integrated case management. In addition, in the emerging person-centered and consumer-directed approaches to long-term care, disabilities and behavioral health services, consumers' services across the continuum are the focus of attention; consumers are increasingly not seen as "cases" to be managed.

Figure 3.1: Common Baseline Service Definition for Case Management

The term "case management services" means services that will assist individuals in gaining access to needed medical, social, educational, and other services. This includes:

1. Assessment of an individual to determine services needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:
    a. Taking consumer history.
    b. Identifying the needs of the individual and completing related documentation.
    c. Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the individual.

2. Development of a specific care plan, based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational and other services needed by the individual, including activities such as ensuring the active participation of the individual and working with the individual (or the individual's authorized health care decision-maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the individual.

3. Referral and related activities to assist and empower an individual to obtain needed services, including activities that help link individuals with medical, social, educational providers or other programs and services that are capable of providing needed services.

4. 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, and which may be with the individual, family members, providers or other entities and conducted as frequently as necessary to help determine such matters as:
    a. Whether services are being furnished in accordance with an individual's care plan.
    b. Whether the services in the care plan are adequate.
    c. Whether there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Such a term does not include the direct delivery of a service other than case management.

For a number of programs providing case management services, the program professional is responsible for providing direct care services in addition to case management services. For example, in the DARS Division for Blind Services (DBS) Blind Children's Vocational Discovery and Development Program, the case manager is referred to as a "specialist" and is responsible for providing numerous direct care services in addition to case management activities. Similarly, case management is just a subset of the overall responsibilities of program professionals (QMRPs staffed in ICFs/MR, social workers in nursing facilities and guardians)

who are also responsible for providing direct services. In these situations, the common service definition would serve as the basis for the case management functions performed by these professionals, but would not replace their direct care responsibilities. To reflect the multifaceted nature of their roles and responsibilities, these types of professionals would also maintain their current titles and not be referred to as case managers.

Advantages

As discussed above, a common terminology to describe case management functions serves as the basis for optimizing case management services and is required to develop standard case manager qualifications; a uniform reimbursement methodology; a uniform screening, triage and referral protocol and an integrated information system. However, the concept of a common service definition and terminology also has important implications for service delivery; such a concept creates a uniform understanding among consumers, providers and state staff regarding the expectations of what case management encompasses. A common service definition and terminology also minimizes disruption of case management when an individual enrolls in additional programs or transfers between programs with case management components. Program management and providers will begin to think consistently about case management services in program development and staffing. In addition, individuals will have the same expectations and understanding, from program to program, of what they should be receiving for case management services.

Potential Barriers and Implementation Risks

While developing a common definition of "case management" is a sensible first step, this step requires a careful deliberation on existing constraints and risks.

- *Regulatory Constraints* – While the definition of case management varies for case management services funded by Medicaid, it is important to note that Medicaid regulations regarding coverage, funding and payment play an important (and restrictive) role in how case management is defined and programs are designed.

  For example, the current definition for "targeted case management," is dictated by federal regulations and would need to be included with any discussion of developing a common definition of "case management" to determine how the definition of targeted case management would be incorporated into the new definition. The Center for Medicare and Medicaid Services dictates that targeted case management 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."[6]

Additionally, Section *6*052 of Deficit Reduction Act of 2005 provides new clarifications regarding Medicaid coverage of targeted case management services.[7] 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:

- 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

Thus, while these requirements may not be applicable to case management services provided through non-Medicaid funding streams, in the context of case

[6] 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).
[7] 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).

management funded by Medicaid, the development of a common service definition would necessarily be constrained by these requirements.

- *Legal Constraints* – Changes in definitions and terminology related to case management services provided through the DSHS Children and Pregnant Women program must be in compliance with Frew v. Hawkins consent decree and associated corrective action plan.

- *State Plan and Waiver Changes* – Changes in definitions and terminology for case management funded by Medicaid would require amendments to the Medicaid State Plan and waiver programs. By amending the Medicaid State Plan to modify service definitions, HHSC would open the entire case management program to federal scrutiny, including components (such as reimbursement methodology, for example) that the state may not want to change. For example, the Department of Family Protective Services (DFPS) has expressed concern that a State Plan amendment to its targeted case management programs could result in CMS modifying their current claiming process for targeted case management services that might result in the loss of federal funding. The state may want to delay implementation of this recommendation for programs that may be exposed to this type of risk.

- *Changes to State Rules and Regulations for Non-Medicaid Services* – Changes in definitions and terminology for case management funded from non-Medicaid sources (e.g., the Children with Special Health Care Needs program) would also require changes to state rules and regulations pertaining to those programs.

- *Existing Culture* – Many service systems, owing to long tradition and practice patterns, may not welcome a change in the definition of case management, however minor it may seem, and some dialogue about the advantages of the common definition should be weighed against disadvantages of making the change. Most likely, the concerns would be related to the implications of a change in service definition for worker performance, compensation and the future of case management as a viable function in the service system.

Implementation Plan

In light of these considerations, we propose the implementation steps described in Table 3.1 on the following page for HHSC to consider in moving forward the recommendation to develop a common service definition and terminology.

HHSC should allow for between 1 to 2 years, depending on changes that are required, to implement this recommendation. In addition, the recommendation should be implemented in conjunction with Recommendation #2 below.

Table 3.1: Implementation Plan for Common Service Definition

Task	Description
1: Develop Policy Rationale	HHSC should develop a policy that includes rationale for developing a common definition for case management. The rationale would include, for example: • The desire to create a level playing field for case managers to legitimize their roles, with potential for movement of case managers across the service systems. • The need to build a foundation to develop a standardized reimbursement methodology. • The desire to foster integration of consumers who may access multiple service systems.
2: Convene Stakeholder Meetings	HHSC should convene stakeholder meetings with involved departments and programs, consumers, providers and advocates to discuss issues and concerns regarding adopting this recommendation and to invite suggestions for implementation.
3: Convene Workgroup	HHSC should convene a small workgroup from the larger stakeholder group to begin drafting a new common definition, using the current working definition as a starting point. The work of the small workgroup (i.e., the drafted definition of case management) should be submitted to the larger stakeholder workgroup for endorsement.
4: Implement New Definition	After the stakeholder group has endorsed the new common definition, HHSC should take the necessary steps to implement the new definition, including changing state rules and obtaining federal approval, which includes negotiating the details of the required changes with the CMS. Details regarding required changes to state rules, waiver programs, etc. are provided in Section V of this report. HHSC should also make current provider outreach materials, training materials and manuals to include the new position descriptions.
5: Issue Change in Service Definition	HHSC should issue the change in service definition to the field and interested parties, consistent with the process and procedures governing public notice.

Cost Estimate

Table 3.2 below provides the estimated costs for implementing this recommendation across the HHSC enterprise.

Table 3.2: Cost Estimate for Implementing Common Services Definition

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing	$51,840	-0-	$103,680	-0-	Staff workgroup of ten from agencies requiring from between 1,080 to 2,160 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours).
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[8]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.
Total	**$519,200**	**-0-**	**$1,038,400**	**-0-**	

[8] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Recommendation #2

Develop guidelines for a tiered qualification system and caseloads for case managers that link case manager qualifications to the consumer's need for levels of intensity and specialized interventions.

Overview

In conjunction with the development of a common service definition, we recommend HHSC develop guidelines for a tiered approach to case manager qualifications and caseloads, recognizing the need for advanced qualifications for more intensive case management for consumers with special needs. As discussed in the Introduction, there is considerable variation in qualification requirements for case managers across programs and some programs that use contracted providers for case management functions (e.g., ADRCs and AAAs) do not specify qualification requirements for case managers. Caseloads also very greatly among programs, from seven in the APS Facility Investigations program to several hundred per case manager in the CBA and CCAD programs.

Our recommended approach to determining guidelines for case manager qualifications and caseloads is proposed below. The qualifications and caseload guidelines would apply to case managers employed by the various HHSC departments as well as case managers employed by contractors. Exceptions would apply to programs employing peer case managers/promotoras, including "family member" case managers. While these individuals may not meet the qualifications guidelines, their unique abilities and relationship to the consumer make them an invaluable option for providing case management to consumers. Additionally, current case managers would be "grandfathered in" under the new qualifications guidelines with requirements for on going training. The qualifications guidelines should also reflect years of experience that an individual has in the role of a case manager or working with a particular population. Additionally, to the extent that existing qualifications requirements for certain programs (e.g., the CPW program) are more stringent than the proposed guidelines, the existing qualification requirements would take precedent over the guidelines unless HHSC specifically indicates otherwise.

Table 3.3: Tiered Case Management

Title	Qualifications	Potential Functions	Caseloads	Performance Standards
Service Coordinator I	Two years of college education with experience or training.	• Screening • Intake • Eligibility	To be developed by HHSC workgroup	To be developed by HHSC workgroup
Service Coordinator II	Bachelor's degree with experience and training in fields applicable to the service systems as certified in accordance with state law.	• Development of individual service plans • Service authorization • Case management • Service arrangement • Monitoring/ follow-up	To be developed by HHSC workgroup	To be developed by HHSC workgroup
Service Coordinator III	Master's degree with experience and training in fields applicable to the service systems, as licensed and certified in accordance with state law.	In addition to the functions of a Service Coordinator II, would include supervisory functions. Would also include specialists trained to provide services to a particular disability group.	To be developed by HHSC workgroup	To be developed by HHSC workgroup

Rationale

During focus groups and interviews, stakeholders commented on the need for standard qualifications for case managers. Additionally, more than half of case managers responding to a voluntary web-based and mail-in survey indicated that they believe that the lack of qualified case managers is a major or moderate problem within the case management system in Texas. The development of standardized qualification guidelines and caseloads would not only increase consistency across programs, but would also enhance the quality of services provided by increasing the level of qualifications of case managers providing services in the programs and tying the qualifications of the case manager to the level of need of the consumer so that the more qualified case managers are providing services to individuals with greater needs. In addition, there are considerable merits to rationalizing the case manager workload and

qualifications, simplifying cross-system coordination and communication and providing clarity to consumers for expectations regarding the qualifications for their case managers.

Table 3.4 below identifies those programs likely to be affected by a change in qualification requirements. The Table provides information on current qualification requirements and indicates whether HHSC would need to change those requirements to meet the recommended guidelines.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
	DADS		
Aging and Disability Resource Center (ADRC)	The state does not specify system navigator qualifications for ADRCs, although it does require the ADRCs to report system navigator qualifications.	Contractors	Possibly.
Area Agencies on Aging (AAA)	The state does not mandate qualifications for care coordinators. Qualifications for care coordinators vary among AAAs.	Contractors	Possibly.
Community Based Alternatives Program (CBA)	There are no specific degree, registration, licensure or certification requirements. Case managers must have experience as case managers in other programs.	DADS staff	Possibly.
Community Care for the Aged and Disabled (CCAD)	There are no specific degree, registration, licensure or certification requirements. Case managers must have experience in other programs.	DADS staff	Possibly.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DADS, continued			
Community Living Assistance and Support Services (CLASS)	Case managers must be licensed by the Texas State Board of Social Work Examiners at the time of employment or no later than nine months after employment as one of the following: a licensed Master's social worker or a licensed Bachelor's social worker. Alternatively, a case manager must have the formal education equivalent of a Bachelor's degree in a health and human services field plus two years of experience in the delivery of human services to persons with disabilities.	Contractors	No.
Consolidated Waiver Program (CWP)	4 years of experience in a waiver program or B.A. in social work or closely related field plus 6 months of experience as a case manager.	DADS (only 3 case managers)	No – Very small program.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DADS, continued			
Deaf/Blind with Multiple Disabilities (DBMD) Waiver	Licensed by Board of Social Work as M.A.-Advanced Clinical Practitioner, M.A.-Advanced Practitioner, M.A. Social Work, Social Worker or Social Work Associate. Alternately, case managers may have a B.A. in social work or Bachelors equivalent in health and human services field plus 2 years of experience in service delivery to those with disabilities; an Associate Degree plus 4 years of experience in service delivery to those with disabilities; or have a high school diploma plus 6 years of experience in service delivery to those with disabilities and be fluent in the communication system used by the consumers.	Contractors (17 service agencies.)	Possibly. Requires high school diploma plus 6 years of experience.
Guardianship Program	B.A. plus 1 year of case manager experience or 60 college credit hours plus certification from the National Guardianship Association. After September 1, 2007, case managers must also be certified by the Texas Guardianship Certification Board.	DADS and contractors	No.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, ***continued***

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DADS, continued			
Home and Community-based Service (HCS) Program	High school diploma plus 2 years of experience in social, behavioral or human services; Licensed RN or LVN plus 1 year of experience in social services; or B.A. in social sciences, behavioral, or human services.	Contracted with 39 MRAs 475 HCS Providers	Yes.
Intermediate Care Facility for the Mentally Retarded (ICF-MR)	QMRPs—B.A. in human services plus 1 year of experience.	State schools and community contractors	No.
Medically Dependent Children Program (MDCP)	Licensed by Texas State Board of Social Work Examiners or B.A. plus 2 years of experience with children with special health care needs.	DADS staff	No.
Mental Retardation Authorities (MRA) Services	B.A. in related field; high school diploma plus 2 years of paid case manager experience or personal experience with a family member with mental retardation. MRAs may require more; MRAs may grandfather in case managers not meeting these requirements if they were hired before April 1, 1999.	Contracted MRA case managers	Possibly. May need to add those with experience with family member(s) with mental retardation.
Nursing Facilities	Licensed by the Texas State Board of Social Worker Examiners; must have B.A. in social work or human services plus 1 year of social work experience.	Contractor	No.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DADS, continued			
Relocation Assistance for Individuals Transitioning from Nursing Facilities to Community Settings	The state does not specify qualification requirements but the contractor proposals must state qualifications.	Contractor	Possibly.
Texas Home Living (TxHmL)Program	B.A. in a related field; high school diploma plus 2 years of paid case manager experience in a state- or federally-funded Parent Case Management Program or have graduated from Partners in Policy Making; or personal experience with a family member with mental retardation. MRAs may require more; MRAs may grandfather in case managers not meeting these requirements if they were hired before April 1, 1999.	Contracted MRA case managers	Yes. High school diploma plus 2 years of experience with family member(s) with mental retardation.
DARS			
Blind Children's Vocational Discovery and Development Program (BCVDD)	M.A. in related field plus 1 year of experience with disabled children or B.A. plus 2 years experience with disabled children.	DARS staff	No.
Early Childhood Intervention (ECI)	Professional or paraprofessionals with ECI training.	Contracted through 58 entities	Possibly.
Vocational Rehabilitation (VR) Services	M.A. in vocational rehabilitation or closely related field; must meet certified rehabilitation counselor national standards; there are some bachelor's level individuals providing services.	DARS staff	No.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, ***continued***

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DFPS			
Adult Protective Services (APS)	B.A. preferably related to social work, gerontology, development disabilities, aging or psychology.	DFPS staff	No. (Yes for supervisors)
Child Protective Services (CPS)	B.A. plus 12 weeks of classroom and on the job training. Completion of a 2 year certification program is not required but is directly tied to pay upgrades.	DFPS staff	No.
DSHS			
Case Management for Children and Pregnant Women (CPW)	Licensed Registered Nurse (with a diploma, an associate's, Bachelor's or advanced degree) or a currently licensed Social Worker (with a Bachelor's or advanced degree). Additionally, case managers must possess 2 years experience in working with children and/or pregnant women. The majority of case managers employed by DSHS are social workers.	DSHS staff, enrolled Medicaid providers approved by DSHS	Yes. Current CPW program requires licensure for all case managers. This requirement would remain intact under the standardized guidelines.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
	DSHS, continued		
Adult Mental Health Case Management	Employees of Community Mental Health Mental Retardations Centers (CMHMRCs); B.A. with hours equivalent to a major in psychology, social work, medicine, nursing, rehabilitation counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, early childhood intervention; or a Registered Nurse; or a High School Diploma plus 3 continuous years of experience in case management as of August 31, 2004. Individuals meeting all of these requirements may perform and submit claims for all case management activities. However, individuals without a B.A. or RN degree cannot administer the uniform assessment.	Contracted with 37 CMHMRCs	Possibly. High school diploma plus 3 years of experience—limited functions; and family members able to be case managers.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
	DSHS, continued		
Children's Mental Health Case Management Services	Employee of CMHMRCs; B.A. with hours equivalent to a major in psychology, social work, medicine, nursing, rehabilitation counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, early childhood intervention; or Registered Nurse; or High School Diploma plus 3 continuous years of experience in case management as of August 31, 2004. Individuals meeting all of these requirements may perform and submit claims for all case management activities. However, individuals without a B.A. or RN degree cannot administer the uniform assessment.	Contracted with 37 CMHMRCs	Possibly. High school diploma plus 3 years experience—limited functions.

Table 3.4: Programs Impacted by Standardization of Case Management Qualifications, *continued*

Program	Case Management Qualifications	Agency or Contractor Staff	Standardized Case Manager Guidelines Different than Current Requirements?
DSHS, continued			
Case Management Services for Children With Special Health Care Needs (CSHCN)	Licensed Masters Social Worker or RN plus 1 year of experience with community programs for CSHCN program; Licensed B.A. Social Worker or RN plus 2 years of experience with community programs for CSHCN program; family member of CSHCN child with experience serving as the case manager; other qualified individuals with experience in community programs serving CSHCN.	DSHS staff and 13 contractors	Yes. Family members and other qualified individuals, although guidelines may not apply to family member providers.

Potential Barriers and Implementation Risks

While mandating qualification requirements would likely have a more significant impact on the provision of case management than implementing them as "guidelines," the inherent challenges in recruiting and retaining individuals with the specified qualification levels could make this type of recommendation difficult to implement. Implementing the standardized qualifications as guidelines mitigates these challenges while promoting consistency across programs. However, because the requirements would not be mandated, there is a risk that they would not be effective in improving service delivery. If HHSC determines that the goals of mandated qualifications are reasonable, and the Legislature concurs, additional funding may be needed for certain departments. We have learned from interviews, stakeholder meetings, etc., that recruiting and retention of case managers is difficult within current budgetary constraints, and it would be difficult to recruit individuals who meet these new standards. In these cases, HHSC would either need to make exceptions to the guidelines and, for example, rely on qualifying years of experience to determine an individual's level of qualification, or provide additional funding for higher education of case managers.

Implementation Plan

We recommend that the implementation steps that HHSC undertakes to accomplish the redefinition of case manager qualifications and caseload guidelines be similar to those outlined in Recommendation #1, as outlined in Table 3.5 below.

The implementation of this recommendation should be closely coordinated with Recommendation #1 and would take approximately one to two years.

Table 3.5: Implementation Plan for Case Manager Qualification and Caseload Guidelines

Task	Description
1: Develop Policy Rationale	HHSC should develop a policy that includes rationale for developing case manager qualifications and caseload expectations. The rationale would include, for example: • Providing a level playing field to legitimize the role of case managers, with potential for movement of case managers across the service systems. • Building a foundation to develop a standardized reimbursement methodology. • Fostering integration of consumers who may access multiple service systems.
2: Convene Stakeholder Meetings	HHSC should convene a stakeholder meeting, including representatives from human resources and fiscal agencies, with involved service systems to discuss issues and concerns regarding adopting this recommendation and invite suggestions for implementation.
3: Convene Workgroup	HHSC should convene a small work group to establish a work plan with time lines to begin drafting new qualifications and caseload guidelines. The workgroup should present its work to the larger stakeholder group for endorsement.
4: Issue Guidelines	HHSC should issue the qualifications and caseload guidelines to the field and interested parties, consistent with the process and procedures governing public notice.

Cost Estimate

Table 3.6 below provides the estimated costs for implementing this recommendation across the HHSC enterprise.

Table 3.6: Cost Estimate for Implementing Case Manager Qualification and Caseload Guidelines

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing costs for development of tiered system	$51,840	-0-	$103,680	-0-	Staff workgroup of ten policy and fiscal staff from agencies requiring from 1,080 to 2,160 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours). Costs for rate analysis staff are included as part of Recommendation #5 (uniform reimbursement methodology), which is inherently related to this recommendation
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[9]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.

[9] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs

Table 3.6: Cost Estimate for Implementing Case Manager Qualification and Caseload Guidelines, *continued*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Educational scholarships to facilitate existing staff to meet higher qualifications	$150,000	$150,000	$450,000	$450,000	Low estimate assumes 100 staff scholarships per year at $1,500 each. High estimate assumes 300 staff scholarships per year at $1,500 each.
Modifications to provider contracts, including incentives for meeting higher qualification guidelines	$2,000,000	$2,000,000	$3,500,000	$3,500,000	Low estimate assumes $2,000,000 per year for incentives to contract providers. High estimate assumes $3,500,000 per year for incentives to contract providers.
Total	**$2,699,200**	**$2,150,000**	**$4,988,400**	**$3,950,000**	

<u>Recommendation #3</u>

Develop a uniform protocol for initial screening, triage, referral (and authorization where applicable) as basic tools to carry out improved case management responsibilities and reduce inefficiency and ineffectiveness in the system.

Overview

Our review has shown that there is no common tool used to make essential case management decisions, such as screening, initial assessment, triage, service linkage and monitoring/oversight. Absent the common protocol, time and effort may be wasted in disputes over eligibility, admission and discharge criteria, and appropriateness of referrals and coordination of care. In fact, based on our review of the current system and interviews with consumers, case managers and state program managers, the intake process is where we identified the most duplication of efforts, especially in screening, assessment for appropriate

by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

services and in service linkages. During the focus groups, many department staff noted administrative difficulties in case management programs and staff from some programs suggested a system to standardize intake and assessment across all departments.

This recommendation parallels efforts to develop common intake instruments being pursued by other states as part of their ADRC programs. Additionally, the recommendation also supports existing programs within the state designed to streamline the intake process, such as the Texas 2-1-1 information system which directs callers to available resources in their regions and allows them to apply for available benefits.

The screening function, though including an initial assessment of consumer needs, is performed to collect baseline information to make an appropriate triage decision. Entry point screening is not the same as an in-depth assessment/evaluation, for which the provider is ultimately responsible, especially in developing a person-centered plan.

Other states adopted uniform protocols for multiple populations as a best practice, especially when developing single point of entry or no wrong door systems. As a part of the process of implementing a point of entry model for long-term care systems, the State of New York gathered feedback from stakeholders, government agencies and providers on what kind of tools are necessary for screenings and referrals. Most respondents stated that screening tools should:

- Address social, psychological, financial, supportive, housing and health needs.
- Be simple and capture only critical information.
- Comply with the Health Insurance, Portability and Accountability Act of 1996 (HIPAA).
- Build upon existing tools currently in use.

HHSC could consider these general standards when developing the common protocol.

Key components of the tool would include consumer demographic information and basic information on physical health, mental health, behavioral health, social supports, educational supports, etc. The tool would also collect information to make an initial eligibility determination for the consumer.[10] In developing such a protocol, we recommend a process that would promote stakeholder buy-in and ownership of the protocols. We also recommend developing different screening instruments for children and adults that would collect similar data, but would address specific age-related requirements.

Many states are using ADRC pilots to redesign their long-term care assessment instruments and processes. The Wisconsin Functional Screen system is an example of a web-based application

[10] A final eligibility determination would still be made at the individual program level.

used to collect information about an individual's functional status, health and need for assistance for various programs that serve the frail elderly and people with developmental or physical disabilities. The Wisconsin Functional Screen has three different screening versions: children's support functional screen, adult functional screen and mental health/AODA functional screen.

According to the Wisconsin Council on Long Term Care Reform the screen works to identify an "inventory of needs" or list of activities that people need to perform, or have performed for them.[11] The screen addresses activities of daily living, instrumental activities of daily living and contains questions about cognition, behavior, diagnoses, transportation and employment. The Functional Screen also contains indicators for mental health problems, substance abuse problems and other conditions. Stakeholders, consumers and clinical practitioners participated in the development of the functional screen.

Figure 3.2 below provides the components of the children's screen.

Figure 3.2: Wisconsin Children's Screen Components[12]

- **Demographics** – including information about county of residence and responsibility, living situation and medical insurance
- **Diagnoses**
- **Mental Health and Psychiatric Symptoms**
- **Behavioral Needs**
- **Activities of Daily Living (ADLs**) – including age appropriate skills in bathing, dressing, grooming, mobility, transfers, eating and toileting
- **Instrumental Activities of Daily Living (IADLs)** – including, as appropriate for the child's age, communication, learning, meal preparation and money management
- **Work and School** – including information about the child's current school/work situation as well as supports needed and interests for future employment
- **Health-Related Services** – including skilled nursing tasks, therapies, and other medically-oriented interventions

The children's screen is a needs inventory and not a complete strengths-based assessment. The "screen development criteria" that Wisconsin used to guide the development of the screen are provided in Table 3.7 on the following page.

[11] Wisconsin Council on Long Term Care Reform, State and Local Stakeholder Advisory Committee, Meeting of November 20th, 2006. Available online: http://www.wcltc.state.wi.us/PDF/StkhlderMin11-20-06.pdf

[12] Ann Pooler, Nachman Sharon, Beth Wroblewski, *Wisconsin Children's Long-Term Supports Functional Screen*, p. 2. Available online: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/cltsfs/cltsfsvalidity.pdf

The Child and Adolescent Needs and Strengths Assessment Tool is another comprehensive assessment tool for children with multi-system needs which could be tailored to asses the strengths and needs of children and their families across systems.[13] The tool contains a group of outcomes management tools for children with multi-system needs. The Buddin Praed Foundation funded the development of the tool to guide service planning and delivery for children and adolescents with mental, emotional and behavioral health needs, mental retardation/developmental disabilities and juvenile justice involvement. The tool can be used either as a prospective tool for service planning decision support or as a retrospective assessment tool to review existing information and reassess individual service plans. The tool provides a structural assessment of children along with a set of dimensions relevant to service planning and/or quality assurance. States that use the Child and Adolescent Needs and Strengths Assessment Tool, including Indiana and Illinois, tailored the tool to reflect the state's practices across child services systems. The development of the tool involved the use of focus groups with a variety of participants including families, representatives of the provider community, case managers and staff.

Table 3.7: Development Criteria for Wisconsin Children's Screening Tool[14]

Criteria	Description
Objectivity and Reliability	The screen is designed to be as objective as possible to reach the highest possible "inter-rater reliability" (two screeners would answer the same way for a given child). Subjectivity must be minimized to ensure fair and proper eligibility determinations, as well as to improve statewide consistency.
Accuracy	Eligibility determinations must be correct and must match current federal and state criteria in every instance.
Brevity	The screen is only a "functional assessment" to determine program eligibility. It serves as a baseline for more in-depth assessment to develop a service plan that reflects each child's and family's strengths, values and preferences.
Inclusiveness	Children of all ages; with emotional, cognitive disabilities, physical disabilities, or developmental disabilities; with or without skilled nursing needs; in any setting from homeless to hospitals or institutions; can be accurately screened with the given choices for each question.
Clarity	Definitions and answer choices, including diagnoses and nursing needs, must be clear to screeners with a broad array of professional backgrounds and experiences.

[13] The tool was developed by John Lyons, Northwestern University, Chicago and stakeholders across multiple states. The assessment instrument is copyrighted by the Buddin Praed Fundation: http://www.buddinpraed.org/cans/.
[14] Ann Pooler, Nachman Sharon, Beth Wroblewski, *Wisconsin Children's Long-Term Supports Functional Screen*, p. 2. Available online: http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/cltsfs/cltsfsvalidity.pdf

Rationale

A common protocol for screening, triage, referral (and authorization, where applicable) could enhance quality and reduce costs through the reduction of duplication of efforts, and improve communication and coordination among different service entities, including service systems that are not part of the optimization project, such as the STAR+PLUS Program. As discussed above, it is also a tool that numerous states have implemented to streamline the intake process. A common initial screening, triage and referral protocol would be most beneficial for consumers with multiple needs, as they would obtain reliable referral information for different services and agencies at their first contact with the system. Also, screening professionals would be able to identify consumers with urgent, unmet need as well as ineligible consumers or consumers inappropriately directed to an agency. The early identification of applicants who are not eligible for services or who require assistance from a different program/agency would conserve the staff time and agency resources otherwise spent on full, lengthy assessments, as well as potentially reduce interest lists. Consequently, consumers who want to access services and are determined eligible would be assessed earlier and would receive wanted services sooner.

Potential Barriers and Implementation Risks

As case management in Texas is delivered by numerous health and human services programs and through a range of program structures with diverse eligibility and triage standards, creating a single protocol for all programs would take time and require cooperation across programs. Even so, the process may be difficult. Training workers to use the intake instrument will assist in the successful implementation of the screening tool In addition, screening for some programs (such as the DFPS APS and CPS programs) requires specific types of training and skill sets to recognize the needs of individuals being served by these programs.

Implementation Plan

While this recommendation is related to the development of a uniform screening tool, and would not take the place of more detailed assessments performed at the programmatic level, a challenge to developing a uniform and standardized protocol for improving consumer access would be the acceptance of some professionals to relinquish the screening function and accept information collected by others. To overcome this challenge to developing a common protocol for screening (assessment), triage, service linkage and monitoring, we recommend some initial planning steps, followed by action steps to implement the recommendation, as described in Table 3.8 on the following page.

Given the complexity of this task, we suggest that at least two years be set aside to complete the development and implementation.

Table 3.8: Implementation Plan for Developing a Uniform Protocol for Initial Screening, Triage and Referral

Task	Description
1: Develop Stakeholder Workgroup and Project Plan	A work group comprised of key stakeholders should be convened to participate in the development of the protocol, guided by an outside facilitator to preserve neutrality, using existing instruments as the baseline for development.
2: Convene Stakeholder Meetings	After the planning stage, we recommend that HHSC convene an expert panel to include appropriate representatives from the programs under consideration for adopting the uniform protocol, including a balanced mix of professional discipline. The workgroup would be responsible for the Subtasks described below.
Subtask 2.1: Review Existing Protocols Used In Texas	Review existing protocols used by all programs to identify a common data set that can be developed into a uniform protocol. It is possible that pre-existing tools currently in use in Texas could be reviewed and modified to serve as a standardized tool. Different tools that would collect similar data could be designed for categories of programs to respond to consumers' different needs (e.g. long-term care programs, mental health programs, children programs and adult programs).
Subtask 2.2: Review Exemplary practices in other states.	Review exemplary practices in other states. The ADRC Technical Assistance Exchange Assessment Tool Matrix (included in Appendix A) provides information and links to assessment tools used by selected states with single point of entry systems.[15] The matrix includes information about the selected states' forms, such as who administers the forms, information elements, how long it takes to administer, for which populations the form is used, whether the forms are available electronically, etc. For example, the work group could review the tools used by Wisconsin, Illinois and Indiana described above, to identify components that could be included in the common tool. These tools are similar to what we are recommending in that they are only a functional assessment to determine program eligibility and serve as a baseline (not as a replacement) for more in-depth assessment to develop a specific service plan.

[15] ADRC, *The ADRC Technical Assistance Exchange Assessment Tool Matrix.* Available online: http://www.adrc-tae.org/tiki-index.php?page_ref_id=415.

Table 3.8: Implementation Plan for Developing a Uniform Protocol for Initial Screening, Triage and Referral, *continued*

Task	Description
Subtask 2.3: Review Information System Capacity and Potential Changes	Review information system capacity and potential changes. This task should be performed in conjunction with Recommendation #4, Developing an Integrated Support Coordination Information System.
Subtask 2.4: Draft Uniform Protocol	Draft the uniform protocol for consideration by HHSC for review and approval.
Subtask 2.5: Recommend Pilot Sites In Texas To Test the Protocol	Recommend strategic pilot sites in Texas to test the protocol. HHSC could use the experience from the piloting to roll this initiative out to statewide implementation.
3. Modify the Uniform Protocol Based on Experience from Pilot Site Tests	Modify the uniform protocol based on experiences and lessons learned from the pilot site tests and submit to HHSC for review an approval.
4. Implement the Final Protocol on a Statewide Basis	After HHSC approves final modification to the uniform protocol, implement the final protocol on a statewide basis.

Cost Estimate

Table 3.9 on the following pages provides the estimated costs for implementing this recommendation over two years.

Table 3.9: Cost Estimate for Implementing a Uniform Protocol for Initial Screening, Triage and Referral

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing	$224,640	-0-	$308,160	-0-	Staff workgroup of 15 FTEs from agencies requiring from 4,680 to 6,420 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours). Assumes that the protocol will not be based on a proprietary tool.
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[16]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.

[16] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Table 3.9: Cost Estimate for Implementing a Uniform Protocol for Initial Screening, Triage and Referral, *continued*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Training	$100,000	$100,000	$300,000	$300,000	Low estimate assumes training prior to implementation will be incorporated into regularly scheduled training components and the use of internet and other low cost training options for ongoing training. High estimate assumes the training of all staff prior to implementation in face-to-face training modalities and similar training for ongoing training.
Total	**$792,000**	**$100,000**	**$1,542,880**	**$300,000**	

Recommendation #4

Integrate management information systems across the various departments to: a) facilitate the sharing of data between departments and, b) standardize the collection and reporting of appropriate data for tracking and monitoring financial performance and outcomes measures.

Overview

Based on the studies we have read, as well as through focus groups and interviews with stakeholders, it appears that one of the major concerns of current case management systems is that data do not support tracking and monitoring, and where outcome measures are available, they are not consistent across programs. Additionally, as part of our assessment of the current system, we found that that the lack of uniform data creates difficulty in comparing utilization and consumers of case management services and expenditures across programs. The design and function of the current system also leads to wide variation in the level of coordination between programs, departments and other organizations. For example, as discussed in the introduction, results of a voluntary case management provider survey (conducted on-line and through a mail-in survey) indicated that approximately two-thirds of survey participants indicated that insufficient coordination across agencies is a major or moderate problem within the case management system in Texas.[17] State staff reported during targeted interviews that effective data sharing among HHSC departments and programs is an issue. A number of departments and programs reported in targeted interviews and focus groups that case managers do not have the information they need about other services that consumers are receiving. Others reported that they rely on self-reported data from consumers. Some case managers expressed concern that consumers would encounter a "wrong door" and subsequently be turned away for services. Additionally, some stakeholders have raised concerns about case managers not knowing what resources are available for their consumers and the need for the consumer, family member or guardian to educate the case managers about the needs of the consumer.

The development of an integrated management information system for case management services would help to address many of these issues and enhance the ability of HHSC to monitor program quality and manage utilization. An integrated system would allow HHSC to standardize outcomes and financial data and reports across all programs to support the ongoing monitoring and evaluation of case management services. The financial metrics would focus primarily on key cost-related metrics such as per consumer cost and utilization and would allow the state to independently measure the performance of the case management program on a quarterly basis. The system would also serve as a centralized warehouse for consumer and provider information and incorporate tools to enhance the ability of case managers to meet the needs of their consumers. The development of an integrated management information system across the various departments and programs is critical to accomplishing these goals.

[17] Approximately 245 individuals participated in the survey.

The management information system would be primarily web-based and could be comprised of a number of different components, including:

- *Consumer Case Management Information* – A centralized database for entering and maintaining consumer information, including:
  - Intake and assessment information
  - Eligibility information
  - Demographics
  - Level of care determination
  - Consumer goals/plan of care
  - Cost/Frequency of service authorized
  - Funding sources
  - Service authorization and referral information
  - Quality assurance measures
  - Contacts and case notes

- *Provider Resource Directory* – A centralized online database of certified providers and community resources available to consumers that provides detailed information on each provider and resource, including capacity, costs, payment source, location, accessibility, languages spoken and hours of operation. The database would be categorized to catalog detailed information on providers and services across the state. Case managers could search by cost, type of payment accepted, hours of operation, category-specific details and proximity to consumer.

- *Reference Manuals and Forms* – A centralized online repository that maintains up-to-date program manuals, memorandums and forms that case managers must complete for various programs.

- *Case Management Tools* – The web-based system would include tools to assist the case managers in the field. For example, the system could include features that automatically generate reminders or the development of "hot lists" which automatically flag cases in need of immediate attention based on pre-determined criteria.

The state could also use an integrated management system to facilitate billing and payment for Medicaid services by linking the state's Medicaid Management Information System (MMIS) to information on Medicaid consumer service plans, service authorizations, budgets, etc. The MMIS would check bills submitted by providers against consumer care plans, service authorizations, budgets, etc., maintained in the integrated information management system to determine that payment is appropriate. To the extent possible, this system should build upon existing systems such as the DADS Client Assignment and Registration (CARE) and Service Authorization System (SAS) systems and the Texas Medicaid and Healthcare Partnership (TMHP), which are currently performing similar types of functions. This integrated management system would serve as an internal control to the state against potential provider billing fraud and abuse. Claims data would not be accessible system-wide.

In addition to centralizing and streamlining data and resources, one of the primary purposes of the information system would be to capture consistent data about case manager functions and outcomes in the areas identified below.

- Caseloads/productivity
- Provision of wrap-around services
- Service utilization, including a comparison of service utilization to service authorization
- Improved consumer experience
- Improved family experience
- Decreased family caregiving burden
- Improved provider experience
- Maintenance or improvement of functional well-being, independence and community participation
- Decreased reporting of unmet needs
- Maintenance or improvement of health status (e.g., improved measures of Activities of Daily Living).
- Prevention of secondary complications

Examples of specific evaluation and outcomes measures, the type and source of data for the measure and the method for evaluating the measure are included in Table 3.10 on the following pages.

Table 3.10: Evaluation Measures for Case Management Services

Specific Measure	Data Type	Data Source	Evaluation Method
Case Management Intervention Variables			
Number of consumers receiving case management per month, by intensity level	Quantitative	Clinical Information System	Monitoring
Average number of new consumers identified for case management per case manager per month	Quantitative	Clinical Information System	Monitoring
Number of face-to face visits per month	Quantitative	Clinical Information System	Monitoring
Number of phone calls to consumers per month	Quantitative	Clinical Information System	Monitoring
Number of referrals to physicians per month	Quantitative	Clinical Information System	Monitoring
Number of referrals to community-based agencies per month	Quantitative	Clinical Information System	Monitoring
Specific consumer education performed	Quantitative	Clinical Information System	Monitoring

Table 3.10: Evaluation Measures for Case Management Services, *continued*

Specific Measure	Data Type	Data Source	Evaluation Method
Influential Factors: Variables that May be Associated with Health Status or Evaluation Outcome Measures			
Case managers' education levels	Categorical	Provider Database/Survey	Survey
Case managers' years of experience	Quantitative	Provider Database/Survey	Survey
Case manager job satisfaction	Ordinal	Survey	Survey
Consumer satisfaction	Ordinal	Survey	Survey
Consumer co-morbidities	Diagnostic Codes	Claims Database or Clinical Information System	Trend Analysis
Consumer Outcomes			
Assessment Score[18]	Quantitative	Clinical Information System	Monitoring
Incidents of institutional care	Quantitative	Claims Database or Clinical Information System	Monitoring
Proportion of consumers who know their case manager	Quantitative	Survey	Survey

[18] Applicability of assessment scores for measuring consumer outcomes may depend on the condition of the consumer. For example, functional assessment scores for persons with Alzheimer's disease will generally decrease over time.

Table 3.10: Evaluation Measures for Case Management Services, *continued*

Specific Measure	Data Type	Data Source	Evaluation Method
Consumer Outcomes, continued			
Proportion of consumers who report that their case manager asked about their preferences	Quantitative	Survey	Survey
Other Measures			
Average expenditures per consumer	Quantitative	Claims Database or Clinical Information System	Trend Analysis
Average expenditures per case manager per consumer	Quantitative	Claims Database or Clinical Information System	Trend Analysis
Average time to respond to requests for services	Quantitative	Clinical Information System	Trend Analysis
Average time to determine/re-determine eligibility	Quantitative	Eligibility System or Clinical Information System	Trend Analysis

In addition to enhancing HHSC program monitoring capabilities, the collection of standardized evaluation and outcomes measures across programs would allow HHSC to consider strategies that encourage quality of care by providing financial incentives to providers that are tied to outcomes measures.

Rationale

A recent white paper published in connection with the United States Health and Human Services ADRC initiative highlights some of the advantages of an integrated management information system, which include:[19]

- Improvement of consumers' and family members' access to information and services through professional information and referral database and software systems, public web sites and on-line consumer decision tools

- Within the constraints of consumer confidentiality issues, improvement of case management by providing service providers and partners access to information about consumers across different levels of government, different organizations and different service systems through the development of Web-based and MMIS and data sharing protocols

- Automation and streamlining of consumer intake, assessment, eligibility determination and case management

- Improvement and standardization of state monitoring capabilities for access and outcomes

Potential Barriers and Implementation Risks

States implementing integrated management information systems have reported numerous challenges, including:[20]

- Need for staff time and resources to be budgeted for design and implementation

- Determination of system specifications and selecting a system vendor

- Differences in IT systems and capacity across participating organizations

- Technical issues related to sharing data across different systems, including, for example, software and hardware compatibility issues

- Privacy and security concerns related to sharing data across organizations. Current state and federal regulations pertaining to consumer confidentiality. To protect confidentiality and privacy, the system can be designed to restrict access so that only

[19] Chapman, Gary and Blakeway, Carrie, "Moving Forward, Opportunities for Information Technology Advances in the Aging Network," The Lewin Group (April 2007).
[20] Chapman, Gary and Blakeway, Carrie, "Moving Forward, Opportunities for Information Technology Advances in the Aging Network," The Lewin Group (April 2007).

individuals with authorization to view a particular type of information are allowed to access it.

Additionally, funding for implementing this recommendation would depend on approval from the State Legislature.

Finally, to the extent that case manager providers will require additional resources to meet the reporting requirement of the new system, the state should consider whether the current reimbursement levels for these providers are sufficient to support these resource requirements.

Implementation Plan

Undertaking a systems integration project of this scale requires extensive planning, time and resources. However, this recommendation does not rely upon HHSC implementing all of various components discussed above at the same time. Instead, HHSC could choose to selectively implement certain components over time based on an evaluation of the need and expected impact of the component on streamlining case management. HHSC may also choose to implement changes as part of ongoing department system improvement projects.

We highlight some initial planning steps which would be critical to implementing this recommendation in Table 3.11 below.

Table 3.11: Implementation Plan for Integrating Management Information Systems Across the Various Departments

Task	Description
1: Develop Stakeholder Workgroup and Project Plan	A work group comprised of key stakeholders should be convened to participate in the development of the integrated information system. Additionally, while this recommendation focuses primarily on the integration of case management-related data in developing an integrated data system, HHSC should also consider how other program data (e.g., data regarding direct service provision) could be incorporated into the integrated system.
2: Identify Key System Features	Identify key features and data elements to be included in the integrated information system.

Table 3.11: Implementation Plan for Integrating Management Information Systems Across the Various Departments, *continued*

Task	Description
3: Perform Assessment of Existing Systems and Systems Under Development	Identify opportunities to build upon existing systems and systems currently under development by departments and programs within HHSC. To the extent possible, HHSC should build upon existing information systems or systems currently under development, both at the state and local levels, when developing the integrated information system. For example, DSHS' mental health program is currently developing a system referred to as Clinical Management for Behavioral Health Services (CMBHS) which incorporates many of the features described above. The first phase of the project would include automated screening and initial assessment, progress notes and treatment planning. When complete, the system would contain the entire medical record and would generate the bills, collect payments and release payment to providers. The system would also link authorizations to treatment plans and allow local authorities to perform provider profiling. DSHS currently has an initial beta release for the CMBHS system scheduled for October of this year and expects to roll out the entire system within the next four years. Data from the CMBHS system could then be linked with other department/program data through the enterprise-wide data warehouse initiative which HHSC is currently undertaking. The warehouse would create a common platform for agencies to link their various data streams and perform analyses, allowing for different agencies to better manage data and eliminate duplicate reporting. This is a long-term project (at least five years) which HHSC is conducting in multiple phases. Initially, the warehouse would link eligibility data with other data sets and reporting capabilities being folded in. Currently, the project is still in the planning stages and HHSC is developing an advanced planning document to obtain funding from the federal government. As such, there would still be an opportunity to incorporate case management data into this system. HHSC should also review how the functionality of existing systems, such as how the changes to the current TIERS eligibility system would be integrated into the information system.

Table 3.11: Implementation Plan for Integrating Management Information Systems Across the Various Departments, *continued*

Task	Description
4: Develop Plan for Expanding and/or Integrating Information Systems	Based on the review of existing systems and systems currently under development, determine feasibility of building upon these systems and, if applicable, develop a plan for expanding and/or integrating these systems.

Cost Estimate

Table 3.12 below provides the estimated costs for implementing this recommendation over a five year period.

Table 3.12: Cost Estimate for Integrating Information Systems

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start-up	Ongoing	
Integrated Management System for Care Coordination (including staffing and technology costs)	$5,700,000	-0-	$11,400,000	-0-	Low estimate includes modifying and using existing case management systems (like DSHS mental health CMBHS System—currently $3.8 million) to share information with the HHSC enterprise-wide data warehouse, currently under development (budgeted at $20 million and not included as a cost in this estimate). High estimate includes the purchase and development of a new system for connecting each department (estimate based on $3.8 million cost for the CMBHS system).

Table 3.12: Cost Estimate for Integrating Information Systems, *continued*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start-up	Ongoing	
Training	$100,000	$100,000	$300,000	$300,000	Low estimate assumes training prior to implementation will be incorporated into regularly scheduled training components and the use of internet and other low cost training options for ongoing training. High estimate assumes the training of all staff prior to implementation in face-to-face training modalities and similar training for ongoing training.
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[21]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.
Total	**$6,267,360**	**-0-**	**$12,634,720**	**$300,000**	

[21] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Recommendation #5

Develop a uniform reimbursement methodology.

Overview

We recommend that reimbursement for case management services be based on a consistent methodology across the HHSC enterprise and should be a unit-based method that reflects the amount of service being provided by the case manager, with reimbursement reflecting both the amount and intensity of services. It is desirable for unit definitions to be consistent (e.g., 15-minute increments). As described in the *Analysis of the Current Case Management System Report*, there is no common reimbursement methodology for case management services across the HHSC enterprise. Case management is paid as a separate service, as part of a bundled program rates or through administrative claiming. Additionally, case management programs for which payments are made on a monthly basis may encourage case managers to schedule visits with their consumers at the end of the month, regardless of whether the consumer may require a visit, so that the case manager can bill for the monthly case management payment. The new methodology would be built upon the case management definition and qualifications developed as part of Recommendations 1 and 2.

We recommend that the uniform reimbursement methodology target Medicaid-financed case management services reimbursed through service claiming (as required under the Deaf/Blind with Multiple Disabilities waiver) and targeted case management, as well as case management services reimbursed through non-Medicaid funding streams. Modifying the reimbursement methodology for case management provided through these programs would be less complex than in other programs such as ICF/MRs and nursing facilities, where case management is part of a bundled rate, or is reimbursed through administrative claiming. As such, these types of programs with bundled reimbursement methodologies or administrative claiming would not be subject to the revised reimbursement methodology.

Currently, the state defines the units of service for case management in several different ways. For example, waiver and targeted case management programs define units of service based either on time, encounters or contacts, or a monthly rate. Details of the current reimbursement units by program are described in Table 3.13 on the following pages.

Table 3.13: Current Case Management Reimbursement Units

Department	Program	Waiver	Targeted Case Management	Administrative Claiming	Reimburse-ment Unit
DADS	Community Based Alternatives Waiver			X	N/A*
DADS	Community Living Assistance and Support Services Waiver	X			Per month
DADS	Consolidated Waiver Program			X	N/A*
DADS	Deaf/Blind with Multiple Disabilities Waiver	X			Per hour
DADS	Home and Community-based Services Waiver	X			Per month
DADS	Medically Dependent Children Program			X	N/A*
DADS	Mental Retardation Local Authority Services		X		Per month
DADS	Texas Home Living Waiver		X		Per month
DARS	Early Childhood Intervention		X		Per month
DARS	Blind Children's Vocational Discovery and Development Program				Per month
DFPS	Targeted Case Management		X		Per month
DSHS	Mental Health – Adults		X		Per 15 minutes of service
DSHS	Mental Health – Children		X		Per 15 minutes of service

Table 3.13: Current Case Management Reimbursement Units, *continued*

Department	Program	Waiver	Targeted Case Management	Administrative Claiming	Reimburse-ment Unit
DSHS	Children and Pregnant Women				Per face to face or telephone contact

* Not applicable because case management services are provided by state employees and are reimbursed through administrative claiming.

We recommend that the state move toward a reimbursement approach based on 15-minute increments which would allow for reimbursement to be based on the level and amount of service actually provided. The approach would also need to consider the interaction of case managers with individuals other than the consumer as part of delivering case management services. In addition, we recommend as part of the reimbursement system design process that the state consider the relationship between case managers and their employers and the potential impact that relationship may have on the services that the case manager authorizes for their consumers. HHSC should also consider the impact that moving to 15-minute billing increments would have on individual waiver allotments/budgets, as controls are necessary so an individual's budget is not used entirely for case management.

We propose that HHSC develop a tiered rate which would be based on the three tiers of case manager qualifications described in Recommendation 2 and would reflect the level and intensify of services provided by each type of case manager. Additionally, because of the number of programs affected by this recommendation, we recommend phasing in the rate changes over two years to minimize disruptions that these changes may cause. In any reimbursement system redesign, however, there will be "winners" and "losers" in terms of how total reimbursement to particular providers is affected. We recommend that HHSC develop the rates to be budget neutral on a system-wide basis for the first two years and that HHSC review the rates every two years to determine whether there is a need to adjust the rates for inflation or cost of living increases.

Rationale

Based on experiences with some of our consumers in other states, the 15-minute increment approach toward reimbursement is in line with what CMS has been advising them. A monthly fee, on the other hand, may create incentives for underutilization and limits the ability of the state to collect utilization data for case management services which makes monitoring of case management in these programs much more difficult.

The DSHS mental health programs have already moved to 15-minute unit billing. DSHS found that moving to 15 minute billing did not increase documentation time and resulted in providers

billing more accurately for services. As a result, DSHS found the overall cost/benefit of moving to the unit-based billing to be positive.

Potential Barriers and Implementation Risks

Moving to 15-minute increments is not without risks or challenges, however. For example:

- *Overutilization and Provider Fraud* – This approach may encourage overutilization of services and would likely increase the oversight responsibilities of the state. HHSC would need to develop robust fraud detection, prevention and monitoring capabilities to reduce this risk.

- *Technological Requirements* – The changes would require significant modifications to billing and payment systems as well as provider training on the new billing process. According to DSHS, there were significant information technology costs related to modifying the billing and payment systems incurred by TMHP as a part of moving to 15-minute unit billing. The implementation of this recommendation would also rely upon the successful implementation of the integrated information system recommendation.

- *Provider Concerns* – Providers are likely to be concerned that the new billing methodology will increase their administrative overhead. Providers may also be concerned that the new methodology will be too restrictive, compared to a monthly rate, in terms of what they can and cannot bill for as case management. However, as discussed above, DSHS found that moving to the 15-minute unit billing did not increase the amount of time providers spend on documenting services.

- *State Plan and Waiver Changes* – As with the prior recommendations, changes to the reimbursement methodology for case management funded by Medicaid would require amendments to the Medicaid State Plan and waiver programs. By amending the Medicaid State Plan to modify reimbursement methodologies, HHSC would open the entire case management program to federal scrutiny, including components that the state may not want to change. HHSC would need to weigh the risks of opening up its State Plan to implement this recommendation (as well as the for the common service definition) before proceeding.

- *Non-Medicaid Case Management Funding* – HHSC would need to address structural funding issues inherent with some non-Medicaid case management programs that are reimbursed on a grant basis (for example, non-Medicaid services provided through MRAs).

- *Funding* – Funding for implementing this recommendation would depend on approval from the State Legislature.

Implementation Plan

This recommendation is closely tied to Recommendations 1 and 2 since the rates would be based on the standard service definition and provider qualifications developed in those tasks. HHSC rate setting staff would likely develop or model rates based on available cost information and data collected from time-and-motion studies. Descriptions of key implementation steps are provide in the following Table 3.14.

Table 3.14: Implementation Plan for Developing a Uniform Reimbursement System

Task	Description
1: Determine Availability of Cost Information	Determine availability of cost information to use as the basis for determining unit-based rates.
2: Collect Available Cost Information	Collect cost information to use in the development of unit-based rates.
3: Develop Model Rates	Using cost information, develop model rates based on staff qualifications.
4: Modify Billing and Payment Systems for New Reimbursement Structure	Work with TMHP to make necessary modifications to the state's MMIS system to accommodate the new reimbursement structure.
5: Implement Uniform Reimbursement System on a Phased in Basis	Implement the uniform reimbursement system on a phased in basis, including: • Developing and conducting provider training on the use of the new reimbursement system • Modifying State Plans and waivers, as necessary • Bringing Provider Billing Manuals up to date

Cost Estimate

Table 3.15 on the following pages provides the estimated costs for implementing this recommendation on a phased-in basis over two years. However, the recommendation assumes that the new rates would be designed to be budget neutral.

Table 3.15: Cost Estimate for Developing a Uniform Reimbursement System[22]

Elements of Costs/Savings	Estimated Costs (Savings),				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
HHSC Rate Setting Staff	$124,800	-0-	$249,600	-0-	Assumes 520 to 1,040 hours total HHSC rate setting staff time, *per program*, would be required to develop the rates. Assumes five programs and that average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs/2,080 annual hours).
TMHP Technical Costs	$140,450	-0-	$2,738,763	-0-	• Assumes $919,921 (6,500 hours) per program for converting a program TMHP administers through the Compass21 system (3 programs, total) and $70,225 (500 hours) per program for converting a program TMHP administers through the Claims Management System (2 programs, total). • Assumes there are no changes to the following systems: V21 (except new reports), Phoenix, PSWin, Ancillary Applications, TexMedConnect or the Portal.
Hardware/ software (Per Program)	$250,000	-0-	$250,000	-0-	Assumes $50,000 per program that TMHP administers through the Compass21 system and the Claims Management System (5 programs total).

[22] Based on estimates provided by the Texas Medicaid and Healthcare Partnership (TMHP) on November 7, 2007

Table 3.15: Cost Estimate for Developing a Uniform Reimbursement System, *continued*[23]

Elements of Costs/Savings	Estimated Costs (Savings),				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Annual Operational Costs (All programs that TMHP administers through the Compass 21 system and Claims Management System	-0-	$203,200	-0-	$203,200	Includes two new provider relation representatives, 11 acute care provider workshops, 6 long-term care provider workshops and publications (provider manuals and bulletins).
Total	**$515,250**	**$203,200**	**$3,238,363**	**$203,200**	

Table 3.16 on the following page provides a crosswalk between each of the primary recommendations described above and the goals of Senate Bill 1188.

[23] Based on estimates provided by the Texas Medicaid and Healthcare Partnership (TMHP) on November 7, 2007

Table 3.16: Crosswalk of Primary Recommendation to Senate Bill 1188

Recommendation	SB 1188 Goals			
	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
Primary Recommendations				
1. Develop a common baseline service definition for "case management"	✓	✓		
2. Develop guidelines for a tiered qualification system and caseloads for case managers	✓	✓		✓
3. Develop a uniform protocol for initial screening, triage, referral	✓	✓		✓
4. Integrate management information systems across the various departments	✓	✓	✓	✓
5. Develop a uniform reimbursement methodology.	✓	✓	✓	✓

SECTION IV: OPTIONS TO SUPPORT THE IMPLEMENTATION OF PRIMARY RECOMMENDATIONS

This section outlines potential options for implementing the primary recommendations identified above. The section explains, from a practical standpoint, what changes to existing policies and procedures (e.g., through State Medicaid Plan and Medicaid waiver amendments) the HHC should make to implement the key recommendations on a statewide basis.

In general, HHSC may implement the primary recommendations through the following methods:

- Make changes to the State plan and rules as required to reflect the recommendations above.
- Request an amendment for certain 1915(c) waivers

A detailed discussion of each of these options is provide below:

1. Make Changes to the State Plan and Rules as Required.

The Medicaid State Plan describes the nature and scope of the state's Medicaid program, as required under Section 1902 of the Social Security Act. The State Plan is a legal contract between the state and the federal government that serves as the basis for the state to receive Federal Financial Participation. State plans must specify the amount, duration and scope for each service offered to the eligible program participants. The following regulations govern the Medicaid State Plan:

- Services must be available on a comparable basis. A state may not provide services that differ in amount or type to one group of beneficiaries or another.
- Beneficiaries must have free choice in selecting from qualified Medicaid service providers.
- Medicaid services must be available statewide and beneficiaries must have ready access to services.
- The state must accept and make a prompt decision concerning a person's application for Medicaid services.
- The state cannot ration or limit due to a funding shortfall for State Plan services, as the state is obligated to provide services in its State Plan to all eligible persons.

According to the *Code of Federal Regulations, Chapter IV, Section 430.18*, a state must amend its State Plan whenever necessary to reflect changes in state law, organization, policy or operations of the programs that affect the elements described in the State Plan. For example, State Plan

amendments for targeted case management have four main sections: the target population to be served, the definition of the service, the qualifications of providers and the reimbursement methodology. CMS regional staff reviews State Plans and Plan amendments, discusses any issues with the Medicaid agency, and consults with central office staff on questions regarding application of federal policy.

As discussed earlier, modifying the State Plan would open the entire case management program to federal scrutiny, including components that the state may not want to change. For example, the Department of Family Protective Services (DFPS) has expressed concern that a State Plan amendment to their targeted case management programs (to implement the recommendation for a common service definition) could expose their current claiming process for targeted case management services changes that may result in the loss of federal funding. HHSC would need to weigh the risks of opening up its State Plan to implement this recommendation (as well as the for the common service definition) before proceeding.

Cost Estimate

Table 4.1 below provides the estimated costs for implementing this option.

Table 4.1: Cost Estimate for State Plan and Rules Changes

Implementation Timeframe	Total Savings/Cost Estimate (State and Federal Dollars)	Assumptions
1 to 2 years	Cost Estimate: $76,800 to $115,200	Assumes State Plan amendments would be required for eight targeted case management programs and that each amendment would require between 200 and 300 hours of staff time. Also assumes the average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs /2,080 annual hours).

2. Request an Amendment for Existing 1915(c) Waivers.

A number of our recommendations affect existing 1915(c) waivers. However, because targeted case management is defined by federal regulations as a non-waiver service provided through the State Plan, some waivers would not have to be amended (i.e., the CWP and MDCP waivers.) In addition, the CLASS, DBMD and HCS waivers include case management as a part of the waiver service array. According to the CMS' Application for a 1915(c) Home and Community-Based Waiver: Instruction, Technical Guide and Review Criteria, if a state wants to change a waiver while it is in effect, the state Medicaid agency must submit an amendment to CMS for review and approval.[24] The CMS Technical Guide specifies that amendments to an approved waiver may be submitted at any time. The state's request for amendment must clearly define the purpose and the nature of the amendment. The state must fully describe the changes contained in the amendment, the rationale for the changes and the impact of changes on waiver consumers.

HHSC must request an amendment for each of the following 1915(c) waivers to develop similar and consistent case management definitions and functions: Community Living Assistance and Support Services (CLASS), Deaf/Blind with Multiple Disabilities Waiver (DBMD) and the Home and Community-based Services (HCS) Program.

Table 4.2 on the following page provides information on how each of our case management optimization recommendations would affect the CLASS, DBMD and HCS waiver programs and the steps required to implement these recommendations in order for case management services to be offered in compliance with federal regulations.

CMS encourages states to obtain public input when developing a major waiver amendment. For example, CMS recommends seeking comments about the draft amendment, conducting focus groups with affected parties (waiver consumers, families, providers, other stakeholders) about the scope and nature of the services offered, and establishing a standing advisory group or committee to assist with the development of the waiver.[25] Texas has already included the majority of these recommendations as tasks within the case management optimization project. In particular, the upcoming Stakeholders Involvement Report will provide stakeholders' input and recommendations that will support the state's decision to implement the case management optimization reform and seek waiver amendments.

CMS also recommends that states confer with CMS when preparing significant waiver amendments, in advance of their formal official submission to CMS. Depending on the implementation strategy pursued by HHSC, HHSC may consider approaching CMS to discuss the proposed reform, its impact on the waivers and the intent to submit individual waiver

[24] CMS," Application for a §1915 (c) HCBS Waiver - Version 3.4: Instruction, Technical Guide and Review Criteria," (November, 2006), p.25. Available online: http://www.hcbs.org/files/100/4982/Final_Version_3_4_Instructions_Technical_Guide_and_Review_Criteria_Nov_2006.pdf.

[25] CMS, Application for a §1915 (c) HCBS Waiver, p.52.

amendments. We acknowledge that amending each individual waiver might lead to new CMS requirements for individual waivers. CMS retains the right to suggest changes to the amendments, as wells as to require additional justification or a transition plan to describe the steps that the state will take to address the impact of the changes on current consumers. However, CMS specifies that "except in foregoing circumstances, CMS will not generally require that a state submit a new waiver to replace an approved waiver either via an amendment or in a renewal application."

Table 4.2: Impact of Case Management Optimization Recommendations on the CLASS, DBMD and HCS Programs

Recommendation	Waiver Issue (Y/N)	Rationale	Implementation Strategy
Develop a common service definition of case management that is applicable to all the systems under review.	Yes.	Case management definition varies across waiver programs. Waivers (CLASS, DBMD and the HCS) that include case management as a covered service should be brought up to date to reflect the new HHSC case management definition.	CMS requires the state to define each of the waiver services in concrete terms of the goods and services that will be provided to waiver consumers, including any conditions that apply to the provision of services. CMS does not approve vague, open-ended or overly broad definitions. The waiver amendments would establish the scope of case management services according to the new HHSC definition.
Develop a tiered qualification system for care managers that links qualifications to the consumer's need for levels of intensity and specialized interventions, so that differential pay scales can support varied responsibilities, as well as provide a career ladder for care managers.	Yes.	Waivers (CLASS, DBMD and the HCS) that include case management as a covered service should be brought up to date to reflect the new requirements for provider qualifications.	CMS also requires the waiver to specify the entities that will conduct case management services on the behalf of waiver consumers, and the standards applied to these entities. The waiver amendments would describe the tiered qualification system for care managers that would link qualifications to the consumer's need for levels of intensity and specialized interventions. The waivers' requirements for provider qualifications should be changed to be consistent with the State Plan amendments for all target populations.

Table 4.2: Impact of Case Management Optimization Recommendations on the CLASS, DBMD and HCS Programs, *continued*

Recommendation	Waiver Issue (Y/N)	Rationale	Implementation Strategy
Develop a uniform protocol for screening, triage, referral (and authorization where applicable), and monitoring as basic tools to carry out improved case management responsibilities and reduce inefficiency and ineffectiveness in the system.	No.	The uniform protocol for screening, triage, referral and monitoring would not change the instruments used by waivers to determine the level of care needed and the development of the individual services plan. The protocol would be used as a tool to identify the appropriate programs under which a person is eligible to receive services.	

Table 4.2: Impact of Case Management Optimization Recommendations on the CLASS, DBMD and HCS Programs, *continued*

Recommendation	Waiver Issue (Y/N)	Rationale	Implementation Strategy
Integrate management information systems across the various departments to facilitate the sharing of data between departments and to standardize the collection and reporting of appropriate data for tracking and monitoring financial performance and outcomes measures.	No.	No reference in the waiver to information systems and their use.	Although implementing this recommendation does not require a waiver amendment, we believe this recommendation would enable HHSC to strengthen its Quality Management Strategy for all three waiver programs by building upon ongoing quality initiatives at DADS, including the Quality Assurance and Quality Improvement Task Force which is implementing Quality Assurance and Quality Improvement in Home and Community-Based Services Real Choice Systems Change Grant CMS awarded to the state. Should the state make such refinements it would report the changes in conjunction with the submission of its annual report. CMS considers that it might be more efficient and effective if the Quality Management Strategy spans multiple HCBS waivers, especially if multiple waivers within a state employ similar quality assurance/quality management methods. As HHSC integrates management information systems across the various departments, as recommended, it would be able to have a common Quality Management Strategy for the CLASS, DBMD and the HCS waivers. The information management system would standardize outcomes and financial data and reports across the waiver programs.

Table 4.2: Impact of Case Management Optimization Recommendations on the CLASS, DBMD and HCS Programs, *continued*

Recommendation	Waiver Issue (Y/N)	Rationale	Implementation Strategy
Develop a consistent unit-based reimbursement methodology across the HHSC enterprise, with reimbursement reflecting both the amount and intensity of services. It is desirable for unit definitions to be consistent (e.g., 15-minute increments).	No.	Waivers (CBA, CWP and the MDCP) that include case management as a covered service based on administrative claiming are excluded from this recommendation.	

Cost Estimate

Table 4.3 below provides the estimated costs for implementing this recommendation.

Table 4.3: Cost Estimate for Waiver Amendments

Implementation Timeframe	Total Savings/Cost Estimate (State and Federal Dollars)	Assumptions
1 to 2 years	Cost Estimate: $11,520 to $23,040	Assumes three waiver programs would need to be amended (Home and Community-based Services (HCS) Program, Community Living Assistance and Support Services (CLASS), and Deaf/Blind with Multiple Disabilities Waiver) and that each amendment would require between 80 and 160 hours of staff time. Also assumes the average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs /2,080 annual hours).

SECTION V: RECOMMENDATIONS FOR INTEGRATING CASE MANAGEMENT SERVICES

The second set of recommendations focuses on how the state can begin to undertake integration of case management services, while advancing a consumer-centered approach, through the statewide expansion of a no wrong door delivery model and the implementation of a centralized system for administering case management services.

1. Undertake a statewide expansion of no wrong door delivery model to integrate case management services.

We recommend HHSC integrate case management through the statewide expansion of the no wrong door delivery model. As described below, HHSC would expand integrated case management for adults and children with single-and multi-system needs through the development of a no wrong door system incorporating features of the ADRC pilot program and the Community Resource Coordination Group (CRCG) program now underway in Texas While we recognize that the development of a no wrong door delivery model is not limited to case management services, and typically involves the full continuum of services, the focus of this recommendation is to use this model as a way to expand integrated case management for children and adults statewide.

This recommendation parallels ongoing efforts within the state designed to streamline the intake process, such as the Texas 2-1-1 information system which directs callers to available resources in their regions and allows them to apply for available benefits, and should be coordinated with these efforts to the extent possible.

The Texas Department of Aging and Disability Services (DADS) recently implemented a "no wrong door" ADRC program in three pilot sites located in the Bexar County, five counties in Central Texas and in Tarrant County, to streamline access and assistance in those service areas for persons age 60 and over and individuals of any age with physical disabilities, mental retardation or developmental disabilities. Each pilot is developing and testing an implementation model that is tailored for the needs and interests of the consumers and resources available in the service area. While each pilot site is developing and testing different service delivery models unique to its area, all three ADRC pilot sites are working to develop a common intake, referral, assessment and follow-up protocols. Also, each ADRC pilot site is developing a consumer information management system to allow sharing consumer and program data among organizations. This effort is part of an overall DADS effort, working through community roundtables to improve referral protocols and access at the community level.

For children's services, Texas has already had a positive experience with inter-system

collaboration through its Community Resource Coordination Group (CRCG) initiative across children's systems at the county level. During focus groups, some case managers recognized the CRCG initiative as a good model on how to coordinate services between different departments and programs. System of Care (SOC) is the accepted best practice for children with multiple system needs ranging from child protective services, juvenile justice, mental health, mental retardation, complex medical needs, substance abuse and educational systems.[26] This model emphasizes child-centered, family-focused, community-based and culturally competent services that can be wrapped around to promote the least restrictive and intensive setting possible for the child. Because many children experience multiple problems addressed by different service systems, by forging collaboration and coordination, duplication of efforts can be turned into effective service interventions with positive outcomes.

We recommend that HHSC implement, on a phased in basis, a no wrong door delivery system which incorporates features of the ADRC and CRCG programs to serve adults and children with single system and multi-system needs. However, because the ADRC pilots in Texas have only recently been implemented or are in the development phase and there are no outcomes reported to date, before implementing this recommendation statewide, HHSC should conduct an evaluation of the pilot programs over the first three years of implementation and based on the information HHSC collects during the evaluation, it can determine the appropriateness and feasibility of implementing a program incorporating features of the ADRC model.

We recommend that HHSC implement two pilots in an urban location and rural location that can build on the state's experience with the ADRC and CRCG programs. Both sites can be important incubators to test whether such integrated case management can help realize better outcomes for consumers and families, while reducing unnecessary utilization of more intensive, out-of-home care. The pilot sites could explore different models, from blended funding to joint purchasing, to lead-agency case management, family/consumer team wrap around model, to a local collaborative using memoranda of understanding (MOUs) as a coordinating tool, to tailor a model that can best meet needs of Texas in urban and rural settings. For example:

- Wrap-around services are intensive, community-based services that seek to prevent more restrictive levels of care. The model is designed to provide a comprehensive array of home and/or school-based services as well as to maximize the involvement of families, personal supports and community resources. The case manager is critical to coordinating these services for the consumer.

- Blended funding is a local level effort that is implemented among a group of agencies that formally integrates a set of funding streams into a single source of

[26] System of Care is a model pioneered by Beth Stroul and others (1986, 1992, 1994) at the Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health, Washington, DC. In recent decades, South Florida University has established a best practice site for tracking all SOC projects at state and local levels.

dollars.[27] A new funding structure is established to administer and allocate the funds to the participating agencies based on negotiated contracts. Blended funding allows systems to fund activities that are not reimbursable through specific categorical programs. The Texas Integrated Funding Initiative (TIFI) program currently being operated in Texas is an example of blended funding.

Memorandums of Understanding (MOUs) establish a formal linkage of partnerships with a shared vision for improving outcomes for families involved in the child welfare system, by providing integrated community support and services.

Rationale

Although Texas' implementation of the ADRC pilot sites is too recent to identify outcomes associated with them, recent studies of ADRC programs in other states have identified improved quality, increased case management flexibility, improved levels of self-determination and increased contacts between consumers and services coordinator as positive outcomes of the programs. For example, a 2005 independent assessment of the Wisconsin Family Care Program, which includes a managed long-term care benefit and a new single entry point system constructed around Aging and ADRCs, indicated:[28]

- 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."[29] Members of the Family Care Program saw significant reduction in institutional settings, in addition to significant reduction in limitations from impairments due to the addition of support services.
- 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.

[27] National Center on Substance Abuse and Child Welfare, "White Paper on Funding Comprehensive Services for Families with Substance Use Disorders in Child welfare and Dependency courts."
[28] 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.
[29] 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.

- 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.

Additionally, according to the 2006 ADRC Progress Report that evaluates the progress of the 2003 and 2004 grantees' programs, the ADRC sites have become trusted places within their communities.[30] Contacts between customers and providers have increased 60 percent within the sites for sites reporting in both periods.

We believe this no wrong-door model also promotes compliance with EPSDT screening requirements for children (including a comprehensive health and developmental history) by enhancing screening efficiency through the use of a common screening protocol, and can be developed with funds made available for compliance. Moreover, children with multi-system needs often require high service expenditures from all systems without appreciable positive outcomes. As System of Care (SOC) pilots in other states have effectively demonstrated, this delivery model has the ability to promote cost containment through reductions in the utilization of out-of-home placement and timely interventions to address children and youth with high risks as well as support family unity.

Potential Barriers and Implementation Risks

As described above, while studies of ADRC programs in other states have identified significant benefits to this model of care, pilots in Texas have only recently been implemented or are in the development phase and there are no outcomes reported to date. As such, before implementing this recommendation statewide, HHSC should conduct an evaluation of the pilot programs after one year of being fully operational to determine the appropriateness and feasibility of implementing a program incorporating features of the ADRC and CRCG programs.

Additional barriers and risks to implementing a no wrong door system include the following:

- *Disruption of Staff* – In the short-term, implementation of a no wrong door system may be disruptive to state staff and providers. Constant communication and training would be critical to minimizing disruption.

- *Communication* – A lack of information and communication among departments, programs and providers can hinder integration. The development of an integrated management information system is therefore critical to the success of a statewide no wrong door system.

- *Performance Measurement* – The coordination of screening, assessment, service authorization and case management is conducive to creating uniform standards,

[30] 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.

including standards of quality care. However, the monitoring of services and service delivery is not necessarily an inherent part of the no wrong door system. Any no wrong door system would need to include components for measuring and monitoring the quality of care provided through the systems. An integrated management information system could include components for performance measurement and monitoring of qualify of care.

- *Technological Requirement* – The implementation of this recommendation would rely upon the successful implementations the integrated information system recommendation.

Implementation Plan

The program would have a multiple entry points (i.e., "no wrong door") for all long-term care services where the consumer could access the entire range of services. The case managers would use a common screening, intake, referral and triage form which would be used to direct the consumer to the appropriate program and resources and to assign them a dedicated case manager that would conduct a complete consumer assessment and develop a plan of care. Consumers would have the same case manager over time to provide continuity of care. To develop this program, we recommend some initial planning steps, followed by action steps to implement the recommendation, as described below in Table 5.1.

Table 5.1: Implementation Plan for Developing a No Wrong Door System Incorporating Features of the ADRC and CRCG Programs for Adults and Children with Single- and Multi-System Needs

Task	Description
1: Choose Workgroup	Choose workgroup members, using nominations from each agency.
2: Develop Strategic Plan	The workgroup should develop a strategic document detailing the purpose and goals of implementing a no wrong door program incorporating features of the ADRC and CRCG programs.
3: Evaluate Existing ADRC Program	The workgroup should conduct an evaluation of the existing ADRC Program to determine whether the program model is appropriate to expand the program statewide.
4: Modify Proposed Delivery Model, as Necessary	Based on the results of the evaluation of the existing ADRC sites, the workgroup should determine whether a statewide implementation of a no wrong door system modeled after the ADRC program is appropriate and, if so, what modification (if any) are necessary to implement pilot sites incorporating features of the ADRC program.
5: Identify and Implement Pilot Sites	The workgroup should identify and implement two pilots in an urban location and rural locations to test integrated case management concepts. • Develop a framework for issuing an RFP for counties/regions to apply for the pilot site, including the necessary start-up cost or seed funds for development, and conditions for participation • Review the applications • Ask applicants to apply for grants to help fund the implementation of this initiative (e.g., Robert Wood Johnson and SAMHSA have funded SOC projects in the past)
6: Modify Delivery Model	Take the best practices and lessons learned from the pilot sites to make any necessary adjustments to the delivery model before expanding the program statewide over a five-year period.

Table 5.1: Implementation Plan for Developing a No Wrong Door System Incorporating Features of the ADRC and CRCG Programs for Adults and Children with Single- and Multi-System Needs, *continued*

Task	Description
7: Begin Statewide Implementation	Begin the statewide implementation of a no wrong door system modeled after the ADRC and CRCG programs.

Cost Estimate

The recommendation for developing a no wrong door system for adults and children with single system and multi-system needs assumes that staff would shift from existing case management activities to the new system and that implementation of the system would result in cost savings gained through administrative efficiencies. The recommendation also assumes that the initial expansion would then be rolled out statewide over time using a larger portion of existing case managers. Until an administrative home is established, the agencies employing the case manager would continue to pay for their salaries and provide administrative support and other necessary operations. The program oversight entity should have supervision and authority over case managers in the expansion. Program oversight should be composed of a unit using staffing from existing programs and should report directly to HHSC or the HHSC's designated agency to host the unit. Estimated savings from this recommendation are detailed in the next section as part of the recommendation related to administering an integrated case management system.

2. Develop a cooperative approach to administering the expansion of integrated case management services.

This recommendation provides potential strategies for HHSC to manage the implementation and ongoing administration of the single entry point systems in a way that targets improved productivity and/or cost savings. We recommend looking at other transformation efforts at HHSC and at the private sector to model an approach for managing the case management optimization efforts in a way to support both better outcomes for consumers and higher efficiency in performing case management.

As a part of House Bill 2292 and other legislation, HHSC successfully undertook a number of agency and administrative consolidation efforts such as procurement, human resources management, information resource management, leasing and facilities management, financial management, and other support and agency functions which resulted in about $50.4 million in savings during the FY 2004-2005 biennium. These efforts relied on agency optimization plans with savings targets and timelines to guide these transformation efforts. Savings in the initial rounds resulted in about a 5 to 6 percent decrease in costs for these transformed functions.[31] However, efforts to privatize the integrated eligibility system have encountered a number of problems. Although some case management functions are currently performed through non-state providers, this recommendation does not anticipate the privatization of additional case management functions and oversight. The recommendation also does not anticipate any efficiency gains to result in a reduction in staff unless populations being served decline in numbers. Any case management efficiencies may allow these programs to provide case management services to cover some of the increase in the number of consumers.

Advantages

Other governmental entities have relied on similar efforts to reduce administrative costs using managed competition, public-private partnerships, or "most efficient organization" models. Managed competitions allow governmental entities to compete either against other governmental entities or against private entities to perform certain governmental services. Public-private partnerships allow governmental entities to build agreements with private entities to divide up functions to provide governmental services. A "most efficient organization" model allows governmental entities to redesign and propose streamlined governmental solutions to provide governmental services either in a cooperative, non-competitive environment or in a competitive manner. These efforts allow governmental entities only, partnered governmental and private entities or private entities to compete to perform certain government services. Examples can be found in city and state governments, including Phoenix, Baltimore, the Federal government, the State of Virginia and other states.

[31] Transition Legislative Oversight Commission, "Commission Update on Health and Human Services Transformation," December 24, 2004, p. 13 and HHSC, "A Progress Report on Consolidation," March, 2005, pp. 20-21.

Given HHSC's recent success with in-house consolidation projects, we recommend that HHSC initiate an agency cooperative/consensus-built effort to craft a case management delivery system to meet its goals. This effort should build its system based upon developing a plan using "most efficient organization" and/or public/private partnership models.

The FY 2006 case management payments that are identifiable from program budgets, federal claiming and contractor payments is approximately $334.8 million and is detailed by program in Table 5.2 on the following page.

Table 5.2: FY 2006 HHSC Case Management Payments by Program ***(notes can be found on the following page)***

Program[1]	Payments[2] (FY 2006)	Cum. Total	Cum. %
Adult and Child Protective Services	$174,080,651	$174,080,651	52.0%
Home and Community-based Services	26,161,138	200,241,789	59.8%
Mental Retardation Local Authority Services	22,531,818	222,773,607	66.5%
Community Based Alternatives Program	21,007,864	243,781,471	72.8%
Community Care for Aged and Disabled: Community Attendant Services	15,685,916	259,467,387	77.5%
Community Care for Aged and Disabled: Primary Care Home	13,574,276	273,041,663	81.6%
Mental Health – Children[3]	12,662,962	285,704,625	85.3%
Division for Early Childhood Intervention[4]	8,063,435	293,768,060	87.8%
Mental Health – Adults[5]	7,788,548	301,556,608	90.1%
Children with Special Health Care Needs Services Program[6]	5,396,161	306,952,769	91.7%
Community Care for Aged and Disabled: Various Title XX and State	5,279,994	312,232,763	93.3%
Children and Pregnant Women[7]	5,015,550	317,248,313	94.8%
Area Agencies on Aging	4,725,303	321,973,616	96.2%
Community Living Assistance and Support Services	3,929,987	325,903,603	97.4%
Texas Home Living[8]	2,963,117	328,866,720	98.2%
Community Care for Aged and Disabled: Day Activity Health Services	2,494,661	331,361,381	99.0%
Relocation Assistance (Nursing Facility to Community Setting)	1,185,466	332,546,847	99.3%
Medically Dependent Children Program	1,158,692	333,705,539	99.7%
Consolidated Waiver Program	340,735	334,046,274	99.8%
Deaf/Blind with Multiple Disabilities Waiver	249,865	334,296,139	99.9%
Guardianship Program	248,661	334,544,800	99.9%
Division for Blind Services – Blind Children's Vocational Discovery and Development Program[9]	224,501	334,769,301	100.0%
Total Payments/Cost	**$334,769,301**		

Notes to Table 5.2:

1. Excludes payments for case management provided through Aging and Disability Resource Center Pilot Sites, Intermediate Care Facilities for the Mentally Retarded and Vocation Rehabilitation because cost/payment data for service coordination provided through these programs is not readily accessible.
2. For programs where case management is provided by state agency staff, "payments" are based on average costs.
3. Medicaid Payments: $7,943,665. Estimated Non-Medicaid payments: $4,719,297.
4. Includes only Medicaid targeted case management payments.
5. Medicaid payments: $2,725,970 (calculated to include state and federal share payments). Estimated Non-Medicaid payments: $5,062,578.
6. Regional staff CSHCN case management: $4,474,959; CSHCN SP contracted services: $921,202.
7. Medicaid Payments: $1,639,620. Regional staff expenditures: $3,375,930.
8. Targeted case management is not provided through the TxHmL Program; MRAs provide case management services to individuals who are enrolled in TxHmL.
9. Includes only Medicaid targeted case management payments.

Potential Barriers and Implementation Risks

The risks and barriers in this approach include the following:

- Large projects can easily be derailed by goals that are not clearly established and where lines of authority are not identified. HHSC should take the lead to set clear goals and to authorize and hold accountable the workgroups and project management. HHSC should provide access to top level decision makers for all project managers.

- Both new and old technology would be essential in improving the efficiency of case management services. Should the technology limit the number of programs and agencies that can be successfully integrated, the overall success of the program would be diminished. One way to mitigate this risk is to establish a technology workgroup with the goal of optimizing a case management system and a budget that is clearly identified. In addition, the case management technology integration should be placed as a priority for the data warehouse project.

- Integrating case management systems may take longer than projected without an organized approach to developing the operational protocols for the integrated system. One way to mitigate this risk would be to initiate a workgroup to develop a systematic approach at the beginning of the project with specific timelines for development of a process map and the basic case management model.

- Delays in implementing an integrated case management system and higher costs than anticipated for technology would limit the savings/efficiencies of the system and possibly create issues for consumers. It is important to continue to serve consumers through this process by keeping current systems running well. In addition, the project would have clearly identified components that should be able to be managed according to that component's timeline. Project management would need to focus workgroups on meeting those goals and coordinate between the projects components.

Implementation Plan

For this redesign effort, HHSC should lead a task force made up of members of each agency currently performing case management functions for the targeted consumers. The task force members should be devoted to the project during the development and implementation phase and should have direct access to agencies' leadership. The task force should be charged with developing an implementation plan, including organizational structure, operating procedures, transition plans, detailed timeline, monitoring and reporting, costs and projected outcomes to meet a required start-up timelines described above.

Agencies currently housing case management functions would continue to provide administrative support. HHSC would shift case management resources from each agency currently operating these functions to the unit that would perform the new case management. HHSC should take into consideration the impact that shifting resources has on various programs, as a shift in resources may have a more significant impact on smaller programs than on larger ones. The task force should be encouraged to leverage existing agency information technology case management systems, as well as integrate the newly recommended case management technology. HHSC should allocate sufficient financial and staff resources to acquire necessary new case management technology through competitive bidding and to implement the technology successfully.

HHSC should assign a priority to this project for information technology staff and other resources necessary to support the optimized case management system. HHSC should approve the plan and select staff to manage the case management unit and the technology projects. HHSC should shift staff and resources to the project as necessary to support fully the development and implementation.

For determining the host agency, HHSC could appoint an agency as the lead. HHSC should allocate sufficient resources to support new case management technology; however, agency proposals should be encouraged to leverage existing systems as well as use the best new case management technology.

Under the approach summarized above, HHSC should hold the task force and agencies accountable for the projected costs and outcomes. HHSC should consider that cost savings

were met if case management operations exceed projected outcomes by five percent and if other agencies' operations reflect a shift in caseloads. We expect a savings in case managers' time with consumers because of fewer coordination efforts needed, less time entering data multiple times and performing of administrative tasks.

HHSC should provide incentives for staff in the new case management models to perform at levels to achieve the desired outcomes. Once outcomes (including customer satisfaction, workload, cost containment and other desired results) are established and measurement is accomplished, HHSC should use these results to determine what salary increases and bonuses would be made available for case managers. Contracts for non-state case management should also include incentives to meet similar outcome expectations.

To develop this program, we recommend some initial planning steps, followed by action steps to implement the recommendation, as described below in Table 5.3.

Table 5.3: Implementation Plan for Administering Integrated Case Management

Task	Description
1: Develop Strategic Plan	Develop a strategic document detailing the purpose and goals of the project, the membership of the task force and its workgroups, the organizational structure and lines of reporting, and the timeline and deadlines for the project.
2: Choose Task Force and Workgroup Members	Choose task force and workgroup members, using nominations from each agency.
3: Establish Workgroups	Establish workgroups using agency experts in relevant fields.
4: Conduct Task Force and Workgroup Meetings	Task force and workgroup meetings would be conducted to accomplish the following Subtasks:
Subtask 4.1	Arrange a general meeting for all parties to be briefed on the project.
Subtask 4.2	Establish initial workgroup meeting for planning project for specific tasks (i.e., qualifications for care managers). Workgroups may include the following: • Information technology • Qualifications for care managers • Procedures and Manual Development • Training development (could be a subset of Procedures and Manual Development) • Measurement of project and consumer outcomes • Funding • Rates

Table 5.3: Implementation Plan for Administering Integrated Case Management, *continued*

Task	Description
Subtask 4.3	Development of Administrative Support for Integrated System, including: • Office and equipment • Human resource operations • Location of support functions
Subtask 4.4	Development of funding for case management system, including • Amount of funding required • Shifting of funding • Prioritizing of project in existing and future information technology projects (e.g. the data warehouse project)
Subtask 4.5	Define the Process for Determining the Host Agency, including: • Develop requirements for host agency • Establish the proposal requirements for both cooperative a approach • Establish a review, evaluation, and revision process for proposals
Subtask 4.6	Establish a system of project accountability, including: • Measure task force and workgroup efforts to time expended • Require regular reporting to management on variations from timelines and tasks • Require corrections or amendments to plan • Measure spending for new case management operations in the task force project and other project costs • Measure outcomes for consumers in the new system

Cost Estimate

HHSC should establish the parameters and goals for the project to achieve, including incorporating the recommendations above in the approach and establishing cost savings and/or productivity improvement goals for the project. Based upon goals met in other HHSC consolidation redesign efforts, the cost savings goal should be established by HHSC at two to three percent in the initial two years of implementation (FY 2010 and FY 2011) to allow for start-up costs and four to five percent during the FY 2012 of current total case management costs for those programs targeted by the ADRC and children's services pilots. These costs should include staff costs (salaries, travel, indirect costs, and other related costs), but exclude information technology costs. Information technology costs should be managed separately given that new case management technology would most likely be required with start-up costs

being significant in the initial years and optimized case management savings accumulating in future years.

The plan should include migrating or phasing in about 40 percent of all case management services to the new system beginning in FY 2010. The plan should target shifting an additional 30 percent of case management services by the beginning of FY 2011; and an additional 30 percent by the beginning of FY 2012. If HHSC chose to accelerate implementation, cost savings would be moved up to prior years. HHSC may decide to phase in the new system by program, agency, region or urban or rural areas as necessary to mitigate any potential service issues for consumers. Details of the implementation costs and savings estimates are provided below in Tables 5.4 and 5.5.

Table 5.4: Cost Estimated for Implementing Integrated Case Management (Combined State and Federal Dollars)

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing	$960,000	-0-	$1,920,000	-0-	Staff workgroup of twenty from agencies requiring from 20,000 to 40,000 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours).
Targeted operational efficiencies from integrated care coordination	Table 5.5 below following this matrix details the cost savings by year for implementing the case management system recommended above using a cooperative approach. A range of savings is presented for FY 2010 and FY 2011 of two to three percent and for FY 2012 of four to five percent. These savings assume that 40 percent of case management services identified would be shifted by the beginning of FY 2010; an additional 30 percent by the beginning of FY 2011; and an additional 30 percent by the beginning of FY 2012. All identified case management services would be included by the beginning of 2013. These savings may be affected by population and caseload growth. These savings do not include changes to services or services utilization.				

Table 5.5: Per Year Savings Estimates for Integrating Case Management Services (Combined State and Federal Dollars)

Col 1.	Col. 2	Col. 3	Col. 4a	Col. 4b
			Per Year Savings Estimates[2]	
			Scenario 1	*Scenario 2*
Phase In Schedule for Single Entry Point Programs	**Total Program Dollars Phased Into New Singly Entry Point System[1]**	**Cumulative Amount**	**2% for FY 2010 and FY 2011 and 4% for FY 2012**	**3% for FY 2010 and FY 2011 and 4% for FY 2012**
40% beginning in FY 2010	$ 60,950,621	$ 60,950,621	$ 1,219,012	$ 1,828,519
30% beginning in FY 2011	45,712,966	106,663,587	2,133,272	3,199,908
30% beginning in FY 2012	45,712,966	152,376,554	6,095,062	7,618,828
		Cumulative Savings	**$ 9,447,346**	**$ 12,647,254**

Notes:

1. Total program dollars phased into integrated system calculated by multiplying the phase in percentage in Column 1 by total FY 2006 case management payments ($152,376,554) for the following programs: Mental Health - Adults, HCS, MRA, TxHmL, Relocation Assistance for Individuals Transitioning from Nursing Facilities, AAA, CBA, CCAD, CLASS, DBMD, CWP, Mental Health - Children, BCVDDP, CPW, CSHCN and MDCP. The ECI, Guardianship and Child and Adult Protective Services Programs are excluded from this analysis. Due to their regulated nature, these Programs may not be initially included as part of the integrated system.

2. One time costs, including, but not limited to, those related to information technology, modifying manuals, training and consumer materials, staff training and possible relocation costs, would reduce overall savings. These costs may vary depending upon the approach HHSC takes to implementing the new system. Additionally, these costs may be mitigated by incorporating documentation modifications and training sessions into regularly scheduled updates and trainings. Information technology costs may also be mitigated by building upon ongoing changes to existing systems.

Table 5.6 below provides a crosswalk between each of the recommendations described above and the goals of Senate Bill 1188.

Table 5.6: Crosswalk of Recommendations to Senate Bill 1188

Recommendation	SB 1188 Goals			
	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**
Recommendations for Integrating Case Management Services				
1. Undertake a statewide expansion of the no wrong door delivery model to integrate case management services	✓	✓		✓
2. Develop a cooperative approach to administering the expansion of integrated case management services.	✓	✓	✓	✓

Overarching Implementation Considerations

It is not necessary for HHSC to take an "all or nothing" approach to implementing the recommendations discussed in this report. Rather, HHSC could choose to selectively target changes to programs that impact the greatest number of consumers. Additionally, HHSC could phase in recommendations, starting with those that lay the foundation for larger system changes. For example, developing a common service definition and provider qualifications guidelines would facilitate the development and implementation of a common reimbursement methodology or developing an integrated management information system and integrating case management services.

SECTION VI: SUMMARY OF COST AND SAVINGS ESTIMATES

Tables 6.1 through 6.8 on the following pages provides a summary of the cost and savings estimates for each recommendation, including the estimated timeframe for implementing the recommendation, the total savings or costs associated with implementing the recommendation and a description of the methodology used for developing the estimate. Caseload growths and other changes to programs may affect the estimates.

Table 6.1: Cost Estimate for Primary Recommendation #1 – Implementing Common Services Definition

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing	$51,840	-0-	$103,680	-0-	Staff workgroup of ten from agencies requiring from between 1,080 to 2,160 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours).
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[32]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.
Total	**$519,200**	**-0-**	**$1,038,400**	**-0-**	
Implementation Timeframe: **1 to 2 years**					

[32] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Table 6.2: Cost Estimate for Primary Recommendation #2 – Implementing Case Manager Qualification and Caseload Guidelines

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing costs for development of tiered system	$51,840	-0-	$103,680	-0-	Staff workgroup of ten policy and fiscal staff from agencies requiring from 1,080 to 2,160 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours).
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[33]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.
Educational scholarships to facilitate existing staff to meet higher qualifications	$150,000	$150,000	$450,000	$450,000	Low estimate assumes 100 staff scholarships per year at $1,500 each. High estimate assumes 300 staff scholarships per year at $1,500 each.

[33] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Table 6.2: Cost Estimate for Primary Recommendation #2 – Implementing Case Manager Qualification and Caseload Guidelines *(Continued)*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Modifications to provider contracts, including incentives for meeting higher qualification guidelines	$2,000,000	$2,000,000	$3,500,000	$3,500,000	Low estimate assumes $2,000,000 per year for provider incentives. High estimate assumes $3,500,000 per year for provider incentives.
Total	**$2,699,200**	**$2,150,000**	**$4,988,400**	**$3,950,000**	
Implementation Timeframe: **1 to 2 years**					

Table 6.3: Cost Estimate for Primary Recommendation #3 – Implementing a Uniform Protocol for Initial Screening, Triage and Referral

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Staffing	$224,640	-0-	$308,160	-0-	Staff workgroup of 15 FTEs from agencies requiring from 4,680 to 6,420 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours). Assumes that the protocol will not be based on a proprietary tool.
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[34]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.

[34] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Table 6.3: Cost Estimate for Primary Recommendation #3 – Implementing a Uniform Protocol for Initial Screening, Triage and Referral *(Continued)*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Training	$100,000	$100,000	$300,000	$300,000	Low estimate assumes training prior to implementation will be incorporated into regularly scheduled training components and the use of internet and other low cost training options for ongoing training. High estimate assumes the training of all staff prior to implementation in face-to-face training modalities and similar training for ongoing training.
Total	**$792,000**	**$100,000**	**$1,542,880**	**$300,000**	
Implementation Timeframe: **2 years**					

Table 6.4: Cost Estimate for Primary Recommendation #4 – Integrating Information Systems

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start-up	Ongoing	
Integrated Management System for Care Coordination (including staffing and technology costs)	$5,700,000	-0-	$11,400,000	-0-	Low estimate includes modifying and using existing case management systems (like DSHS mental health CMBHS System—currently $3.8 million) to share information with the HHSC enterprise-wide data warehouse, currently under development (budgeted at $20 million and not included as a cost in this estimate). High estimate includes the purchase and development of a new system for connecting each department (estimate based on $3.8 million cost for the CMBHS system).
Training	$100,000	$100,000	$300,000	$300,000	Low estimate assumes training prior to implementation will be incorporated into regularly scheduled training components and the use of internet and other low cost training options for ongoing training. High estimate assumes the training of all staff prior to implementation in face-to-face training modalities and similar training for ongoing training.

Table 6.4: Cost Estimate for Primary Recommendation #4 – Integrating Information Systems *(Continued)*

Elements of Costs/Savings	Estimated Costs (Savings)				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Training Materials, Personnel Manuals, and other related materials	$467,360	-0-	$934,720[35]	-0-	Low estimate is equal to one-half the high estimate and assumes changes coincide with the training and materials changes required to implement a 15-minute billing increment reimbursement methodology (see Recommendation #5). High estimate assumes trainings and re-issuance of all materials will occur outside of the change in reimbursement methodology.
Total	**$6,267,360**	**-0-**	**$12,634,720**	**$300,000**	
Implementation Timeframe: **5 years**					

[35] Based on TMHP estimate for operating costs related to implementing 15 minute billing increments provided by TMHP on November 7, 2007. Calculated by dividing the TMHP operating cost estimate of $203,200 for five programs by five (to determine a per program estimate) and multiplying by the 23 (the number of case management programs across the HHSC enterprise to which this recommendation could apply.)

Table 6.5: Cost Estimate for Primary Recommendation #5 – Developing a Uniform Reimbursement System[36]

Elements of Costs/Savings	Estimated Costs (Savings),				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
HHSC Rate Setting Staff	$124,800	-0-	$249,600	-0-	Assumes 520 to 1,040 hours total HHSC rate setting staff time, *per program,* would be required to develop the rates. Assumes five programs and that average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs/2,080 annual hours).
TMHP Technical Costs	$140,450	-0-	$2,738,763	-0-	• Assumes $919,921 (6,500 hours) per program for converting a program TMHP administers through the Compass21 system (3 programs, total) and $70,225 (500 hours) per program for converting a program TMHP administers through the Claims Management System (2 programs, total). • Assumes there are no changes to the following systems: V21 (except new reports), Phoenix, PSWin, Ancillary Applications, TexMedConnect or the Portal.
Hardware/ software (Per Program)	$250,000	-0-	$250,000	-0-	Assumes $50,000 per program that TMHP administers through the Compass21 system and the Claims Management System (5 programs total).

[36] Based on estimates provided by the Texas Medicaid and Healthcare Partnership (TMHP) on November 7, 2007

Table 6.5: Cost Estimate for Primary Recommendation #5 – Developing a Uniform Reimbursement System *(Continued)*

Elements of Costs/Savings	Estimated Costs (Savings),				Assumptions
	Low		High		
	Start- up	Ongoing	Start- up	Ongoing	
Annual Operational Costs (All programs that TMHP administers through the Compass 21 system and Claims Management System)	-0-	$203,200	-0-	$203,200	Includes two new provider relation representatives, 11 acute care provider workshops, 6 long-term care provider workshops and publications (provider manuals and bulletins).
Total	**$515,250**	**$203,200**	**$3,238,363**	**$203,200**	
Implementation Timeframe: **2 years**					

Table 6.6: Cost Estimates for Options to Support the Implementation of the Primary Recommendations

Recommendation	Implementation Timeframe	Total Savings/ Cost Estimate (State and Federal Dollars)	Methodology/Assumptions
1. Make Changes to the State Plan and Rules as Required.	1 to 2 years	Cost Estimate: $76,800 to $115,200	Assumes State Plan amendments would be required for eight targeted case management programs and that each amendment would require between 200 and 300 hours of staff time. Also assumes the average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs /2,080 annual hours).
2. Request an Amendment for Existing 1915(c) Waivers.	1 to 2 years	Cost Estimate: $11,520 to $23,040	Assumes three waiver programs would need to be amended (Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), and Deaf/Blind with Multiple Disabilities (DBMD)) and that each amendment would require between 80 and 160 hours of staff time. Also assumes the average cost per hour of staff time is $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other project costs /2,080 annual hours).

Table 6.7: Cost Estimates for Integrating Case Management Services

Recommendation	Implementation Timeframe	Total Savings/ Cost Estimate (State and Federal Dollars)	Methodology/Assumptions
1. Undertake a statewide expansion of no wrong door delivery model to integrate case management services.	5 years	See Table 6.8 following this matrix.	The recommendation for developing a no wrong door system for adults and children with single system and multi-system needs assumes that staff would shift from existing case management activities to the new system and that implementation of the system would result in cost savings gained through administrative efficiencies. The recommendation also assumes that the initial expansion would then be rolled out statewide over time using a larger portion of existing case managers. Until an administrative home is established, the agencies employing the case manager would continue to pay for their salaries and provide administrative support and other necessary operations. The program oversight entity should have supervision and authority over case managers in the expansion. Program oversight should be composed of a unit using staffing from existing programs and should report directly to HHSC or the HHSC's designated agency to host the unit. Estimated savings from this recommendation are detailed in the next section as part of the recommendation related to administering an integrated case management system.

Table 6.7: Cost Estimates for Integrating Case Management Services *(Continued)*

Recommendation	Implementation Timeframe	Total Savings/ Cost Estimate (State and Federal Dollars)	Methodology/Assumptions
2. Develop a cooperative approach to administering the expansion of integrated services coordination services.	2009 through 2011	***Staffing Costs:*** $960,000 - $1,920,000	Staff workgroup of twenty from agencies requiring from 20,000 to 40,000 hours total staff time. Assumes an average cost per hour of staff time of $48.00 per hour ($80,000 average annual salary with indirect costs and a 25 percent add-on for travel and other related costs/2,080 annual hours).
		Targeted operational efficiencies from integrated care coordination	Table 6.8 below following this matrix details the cost savings by year for implementing the case management system recommended above using a cooperative approach. A range of savings is presented for FY 2009 and FY 2010 of two to three percent and for FY 2011 of four to five percent. These savings assume that 40 percent of case management services identified would be shifted by the beginning of FY 2009; an additional 30 percent by the beginning of FY 2010; and an additional 30 percent by the beginning of FY 2011. All identified case management services would be included by the beginning of 2012. These savings may be affected by population and caseload growth. These savings do not include changes to services or services utilization.

Table 6.8: Per Year Savings Estimates for Integrating Case Management Services (Combined State and Federal Dollars)

Col 1.	Col. 2	Col. 3	Col. 4a	Col. 4b
			Per Year Savings Estimates[2]	
			Scenario 1	*Scenario 2*
Phase In Schedule for Single Entry Point Programs	**Total Program Dollars Phased Into New Singly Entry Point System[1]**	**Cumulative Amount**	**2% for FY 2010 and FY 2011 and 4% for FY 2012**	**3% for FY 2010 and FY 2011 and 4% for FY 2012**
40% beginning in FY 2010	$ 60,950,621	$ 60,950,621	$ 1,219,012	$ 1,828,519
30% beginning in FY 2011	45,712,966	106,663,587	2,133,272	3,199,908
30% beginning in FY 2012	45,712,966	152,376,554	6,095,062	7,618,828
		Cumulative Savings	**$ 9,447,346**	**$ 12,647,254**

Notes:

1. Total program dollars phased into integrated system calculated by multiplying the phase in percentage in Column 1 by total FY 2006 case management payments ($152,376,554) for the following programs: Mental Health - Adults, HCS, MRA, TxHmL, Relocation Assistance for Individuals Transitioning from Nursing Facilities, AAA, CBA, CCAD, CLASS, DBMD, CWP, Mental Health - Children, BCVDDP, CPW, CSHCN and MDCP. The ECI, Guardianship and Child and Adult Protective Services Programs are excluded from this analysis. Due to their regulated nature, these Programs may not be initially included as part of the integrated system.

2. One time costs, including, but not limited to, those related to information technology, modifying manuals, training and consumer materials, staff training and possible relocation costs, would reduce overall savings. These costs may vary depending upon the approach HHSC takes to implementing the new system. Additionally, these costs may be mitigated by incorporating documentation modifications and training sessions into regularly scheduled updates and trainings. Information technology costs may also be mitigated by building upon ongoing changes to existing systems.

SECTION VII: CONCLUSION

This report provides a draft of our key recommendations to HHSC which provide the basis for optimizing case management services in Texas and addressing our major findings from our review of the current case management system, how these recommendations should be implemented and, where available, estimates of costs and/or savings associated with the recommendations.

APPENDIX

The Aging and Disability Resource Center Technical (ADRC) Assistance Exchange Assessment Tool Matrix

Navigant Consulting, Inc.

System/Form Name	Information Elements	Responsible Entity	Administering Staff	Staff Training	Format: Paper/ Automated	Populations Covered			
						Older Adults	PWD	DD	Other
Long Term Care IADL Eligibility Assessment (ULTC 100.2 updated 9/22/03)	ADLs, supervision (including: behaviors, cognitive), demographics, environment, risk, advance directives, MI/MR, level of care determination, strengths assessment and evaluation, self reported physical health, LTC plan.					Yes (60+)	Yes (18-59)		
CHAT	Two assessment tools: 1) Minimum data set-home care (MDS-HC) used for Medicaid waiver programs; and 2) a shorter psychosocial assessment tool for state funded HCBS. It also includes client assessment protocols (CAPS), used to develop care plans. CHAT contains a client evaluation of services and a worksheet to determine client's share of costs (income is self reported).	Area Agencies on Aging	CHAT specialists or Case Managers *special staff positions for data entry, updating and managing the process*	All staff undergo extensive training to make sure callers are getting appropriate information.	Automated *In home assessments are completed by case managers on laptops*	Yes (60+)	Yes		
Illinois Department on Aging Choices for Care Assessment Form IL-402-1230 (Rev. 12/03)	Demographic Information, Financial Declaration, service selection and applicant/client certification, mini-mental state examination, level of cognitive impairment, determination of need, Financial data, case documentation for the determination of need (DON, meds, formal/informal supports, special service instructions), physician's name, emergency contact, advance directives.	State Department on Aging	Certified Case Managers thru IDOA contracted Case Coordination Units are allowed to complete the Choice Assessment Form for CCP or facility placement	Required to attend a Preliminary Training for a temporary certificate good for 6 months. Before the 6 months is complete, they earn a certification card that is good for 18 months. A Recertification class or conference must be attended to extend certification for 18 months.	Paper *a few forms have been approved for electronic use, the technical, confidential and fiscal aspects are being reviewed for electronic formatting and a demonstration project using laptops is under consideration*	Yes (60+) *excluding SMI and DD*			Some CMs also contract with the Office of Rehabilitative Services to conduct hospital based nursing home prescreenings for those under 60 years of age, excluding MI/DD.

System/Form Name	Information Elements	Responsible Entity	Administering Staff	Staff Training	Format: Paper/ Automated	Populations Covered			
						Older Adults	PWD	DD	Other
INsite	Individuals access services by calling one of the 16 AAA offices. Data tracking begins with initial assessment. Once approved for waiver, client can choose CM of their choice who will database to enter following information: demographics, functional assessments, level of care determination, family and community support systems, limitation of ADL's and IADL's, nutrition, consumer goals, planned services, cost/frequency of services authorized, funding sources, initiation and stop dates, quality assurance measures, case notes.	State Division of Disability, Aging and Rehabilitation Services (a unit of the Family and Social Services Administration)	Certified Staff at AAA's, private case management groups, the State Aging Bureau, and the State Medicaid unit.	Certified by DDARS	Automated	Yes	Yes		
Medical Eligibility Determination Tool (MED Ver 5.0 updated 7/1/03)	Background information including identification information; clinical detail including professional nursing services, special treatment and therapies, cognition, problem behavior, physical functioning/structural problems, medications, diagnoses, communication, vision, nutrition, continence, balance, oral/dental, skin conditions, IADLs, environmental, mood; scoring sheets, Community Options Care Plan Summary, outcomes.	Outside vendor *administration* Bureau of Elder and Adult Services *planning, policy development, coordination, and evaluation*	Nurses *must have community health experience*	Several weeks training at start of employment, then mentoring until can do assessment indpendently (about 6 months).	Automated *use laptops at face-to-face meetings*				Adults 18+ who want access either to NF admission or Community LTC programs.
MI Choice Care Management Assessment (ver 1.4.0.0. updated 3/30/00)	Identifying information; social functioning; informal support services; environmental assessment; cognitive patterns; mood and behavior patterns; disease diagnoses; disabilities; health conditions; nutritional; dental; vision; skin; continence; physical functioning; service utilization; medications; vitals.	Local Waiver Agencies	Social Worker and Nurse	Training in assessment completion protocol.	Both *blank forms capture information, which is scanned into MIS that is financially supported by the waiver agencies*	Yes (65+)	Yes (18-64)		

System/Form Name	Information Elements	Responsible Entity	Administering Staff	Staff Training	Format: Paper/ Automated	Populations Covered			
						Older Adults	PWD	DD	Other
Minnesota Long-Term Care Consultation Services Assessment Form: SW Section (DHS-3428A updated 11/03) and PHN Section (DHS-3428A updated 10/04)	**SW Section:** Assessment activity information; client information; informant information; comments; caregiver support/social resources; emotional and mental health; self preservation and safety; results; service plan summary; LTC assessment form. **PHN Section:** Health assessment; ADLs; IADLs; caregiver assessment.	State Department of Human Services	Social Worker or Public Health Nurse	Training provided by policy staff from Aging and Adult Services section of DHS; training provided to new workers at least 4 times per year and as requested by county.	Both *LTC assessment forms are writeable and mergeable. Long Term Care Consultation staff complete assessments using laptop, then save assessment data electronically for future use and updating, or for merging with electronic version of the LTC screening tool. Some forms available in "readable" format only.*	Yes	Yes (under 65)	Yes	
CAP/DA Data Set January 2004	Client identification, date/reason for assessment, cognitive status, mood & behavior patterns, communication/ hearing patterns, vision, disease diagnosis, health conditions, medications, oral/nutritional status, continence, skin condition, physical functioning & structural problems (ADLs & IADLs), special treatments & procedures, home/ environment, social support, economic status, comments, assessment certification.	Division of Medical Assistance	Nurses and Social Workers	Training in local agencies in how to use forms, conduct assessments, be a case manager.	Automated *web-based*	Yes	Yes (19-59)		
NJ EASE Comprehensive Assessment Tool	**Section 2:** benefits screening, demographics, emergency contact/primary caregiver, primary health care provider, current informal services, living arrangement/physical environment, functional status (ADLs and IADLs), support systems, finances, follow-up outcome, quality assurance. **Section 3 (extended assessment):** physical health assessment (medical condition/diagnosis), physical health (professional visits), physical health (medications), psychosocial assessment, physical health assessment (physical functioning, communications, hearing, vision, nutrition status, and lifestyle, special treatments and procedures, assistive devices/equipment, caregiver interview, assessment summary.	State Department of Health and Senior Services	Outreach Workers *Section 2 during home visit* and Care Managers *Section 3 during home visit*	Care Managers have a BA or MS in social science or health related field and are licensed or certified as required by NJ law and/or agency policy. They complete NJ EASE lead agency orientation and mandatory NJ EASE Basic Care Management training within 18 months of becoming a care manager, as well as continuing education.	Automated	Yes (60+)			Receiving services through Jersey Assistance for Community Caregiving (JACC), Community Care Program for the Elderly and Disabled (CCPED), or Enhanced Community Options (ECO) Medicaid Waivers

System/Form Name	Information Elements	Responsible Entity	Administering Staff	Staff Training	Format: Paper/ Automated	Populations Covered				Approximate Time to Administer	Statewide or Local	Programs Covered	Links to Forms
						Older Adults	PWD	DD	Other				
Oregon Access	Eligibility and care planning, medical (medications, diagnosis, treatments/procedures, durable medical equipment, allergies, health history, pain, and supports); mobility (level of need, equipment, falls, and supports); personal care (eating, special diet, bathing, hygiene, grooming, dressing, skin care and foot care); elimination (toileting, bowel, and bladder); communication (vision, hearing, and speech & language); mental status (cognition/memory, behavior, mood, sleep, losses, suicide, geriatric depression scale, Mini Mental State Exam); household management (phone, housekeeping, laundry, meal prep, financial management, shop, transport, pet care, house/yard); personal elements (alcohol, tobacco, drug, exercise, employment/interests, education, legal, spirituality); environment (physical and community); change log; care planning (calculate needs, ability to pay, cost of services needed, and provider list); assessment type, date and history.	Seniors and People with Disabilities Division, State Department of Human Services	Case Managers *nurses do nursing assessment section if client referred by case worker*	Training to use the software program. Provided TA assistance and continued training.	Automated *On laptops in the home*				Medicaid clients (65+), Older Americans Act clients (60+), Oregon Project Indpendence clients (60+)	1 hour	Statewide	Medicaid State plan, Medicaid Waiver and State funded services	Hardcopy print screens available as requested to the listed state contact.
Texoma Real Choice Program Assessment	Demographic information, income, QMB, SLMB, formal and informal support systems, medical background, advance directive, disability, medications, sensory/communications, nutrition, emotional health, other medical concerns. Separate client needs assessment covers IADLs and ADLs. Separate mental health assessment.	Area Agency on Aging	Care coordinators/ navigators and benefit counselors	Specialized training for specific job titles.	Both	Yes (60+)	Yes			Varies	SPE specific to this AAA	State and Federal funded	http://www.hcbs.org/moreInfo.php/topic/33/ofs/30/doc/287/Texoma_Real_Choice_
Comprehensive Assessment Reporting Evaluation (CARE)	Demographics, environmental, medical, indicators, communication, psychological/social, personal elements, mobility, toileting, eating, hygiene, household tasks, functional status, care plan, pending respite, QA monitoring, history.	Aging and Disability Services Administration *a statewide network of Home and Community Services Offices administers the assessment, authorizes services and determines financial eligibility*	Social Workers *MSW or BA + 2 yrs exp. with assessments* or Nurses *with Masters degree*	2 days policy training and 2 days of application training on the CARE tool.	Automated *use laptops during face-to-face visits*	Yes	Yes			2.5 hours *includes generating a service plan*	Statewide	Medicaid Personal Care and Waiver Programs	http://www.adrc-tae.org/documents/washcare.pdf
Functional Screen	Demographics, residence, ADLs, IADLs, overnight care, employment, diagnoses, health related services, communication, cognition, behaviors-mental health, risk.	Wisconsin Department of Health and Family Services	Experienced professionals who have taken a training course and have passed a certification exam can administer the screen.	Online training course and exam.	The screen is adminstered on the Web and must be entered on-line	Yes	Yes		Children's Version	Unknown	Statewide	Medicaid Waiver Programs and State Funded Programs	http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/PaperFormV3.pdf