Texas Health and Human Services Commission

Case Management Optimization

WAIVER FEASIBILITY ASSESSMENT

NAVIGANT
CONSULTING

Texas Optimization of Case Management
Waiver Feasibility Assessment

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EXECUTIVE SUMMARY

In 2005, the Texas Legislature enacted Senate Bill 1188, which directs the Texas Health and Human Services Commission (HHSC) to assess, review and undertake optimization of case management programs and services across the health and human services (HHS) enterprise. The HHS enterprise includes HHSC, the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS). Optimization efforts are to include:

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

The HHSC contracted with Navigant Consulting, Inc. for assistance in the optimization of the state's case management services. This report responds to Section 2.4.1.4 of the HHSC request for proposal (RFP). Section 2.4.1.4 indicates that the contractor will determine the feasibility of combining under a single 1115 or 1915(c) federal waiver, utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures implemented with respect to the Medicaid program.

To determine the feasibility of using a federal waiver as described above, Navigant Consulting considered the results of several earlier project tasks, including: a summary of best practices in case management used by other states and other payers; an analysis of current case management systems; a review of stakeholder comments on reports, stakeholders' surveys and focus groups results; and the development of recommendations to optimize case management activities. These analyses are summarized in a number of reports.

We reviewed the definitions of the services identified for potential consolidations:

- *Utilization management* practices monitor resource allocation and consumption of services.
- *Case management and care coordination* activities (under various names) generally have two key features: providing a connection between individuals and the services and

supports they need and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals. Our recommendations would create a standard definition for these services and rename them "service coordination."

- *High-cost targeting* programs are implemented to contain costs incurred by individuals with multiple and complex needs.

- *Provider incentives* programs link reimbursement formulas to appropriate processes, quality and outcomes.

We also reviewed the use of quality and cost control activities in the programs under consideration in this study, as well as the regulations and use of 1915(c) and 1115 waiver programs.

Based on these reviews and, in particular, the recommendations we made regarding optimizing case management services in Texas, we concluded that a waiver program to combine the above-mentioned services into a single program is neither feasible nor necessary to achieve objectives defined throughout our study. Consolidating services under a single waiver is not feasible for two main reasons:

- The Centers for Medicare and Medicaid Service (CMS) is unlikely to approve a cross-disability waiver. The Centers for Medicare and Medicaid Services' current policy is to reject cross-disability 1915(c) waiver applications; we anticipate they will use the same policy in evaluating cross-disability 1115 waivers.

- Even if such a waiver received federal approval, it would involve creating an organization that would be responsible for the consolidated activities and would require major systems changes and additional administrative burden – challenges we believe are unnecessary given that much of what would be gained by such an approach could likely be achieved without a waiver through state plan and waiver amendments.

In Navigant Consulting's case management optimization recommendations, we recommend an initial integration of all HHS enterprise case management and care coordination services. If implemented, we believe such an approach would provide HHSC with a basis for further development and consolidation of other functions such as utilization management, provider incentive practices and high cost-targeting. For example:

- Our recommendations would create a common definition of "case management" across all departments under study and name the services "service coordination."

While this change requires modifications to current waivers, it does not require new waiver programs.[1]

- Our recommendations promote additional quality and cost control measures; consistent educational requirements for service providers; common protocols for screening, triage and referrals; standardized data collection and reporting; and a uniform reimbursement system. All of these recommendations can be implemented without a waiver.

- Our recommendations also leave open the possibility of standardized provider incentives (for both cost and quality) that would be possible after a uniform fee-for-service payment system is implemented.

- Our recommendations would facilitate the consolidation of utilization management practices across the HHS enterprise in the future. Consolidating and standardizing utilization management functions could be a second step after implementing the recommendations detailed in our *Case Management Optimization Recommendations for Improving Texas Case Management Delivery Report.*

Additionally, as stated within the RFP that governs Navigant Consulting's work to optimize case management services, our study excludes case management services provided by managed care or disease management programs. It is within these other programs that high-cost targeting and provider incentives are usually found. After implementation of our recommendations regarding non-managed care services, HHSC could assess how to best integrate its current managed care and disease management programs into the consolidated case management system. Should HHSC determine at a later date that case management within managed care programs should be consolidated, additional analyses may be necessary to determine how this consolidation should be implemented.

In conclusion, by implementing Navigant Consulting's case management optimization recommendations, HHSC would be able to promote and consolidate utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures without the use of a Medicaid waiver. Consolidating these functions into a federal waiver is not feasible due to CMS' policy regarding cross-disability waivers and because the advantages of such a waiver are far outweighed by the administrative burden and challenges related to the major system changes that such a waiver would require.

[1] We found in our review of the various departments that provide case management services that "case management" has various definitions and is referred to in various ways. We do not view case management and service coordination differently.

Texas Case Management Optimization
Waiver Feasibility Assessment

I. INTRODUCTION

To determine the feasibility of using a federal waiver as requested by HHSC, Navigant Consulting considered the results of the following phases of our contract with HHSC to optimize the State's case management services:

- *Case Management Optimization Best Practices and Emerging Trends in Case Management Report*: This report defines and identifies case management models used by other states and the commercial sector. The report discusses single points of entry systems, "No Wrong Door" and integrated funding models as states' best practices that attempt to improve consumer access by improving the structure and functions of access entities.

- *Case Management Optimization Analysis of Current Case Management Systems Report*: This report provides a summary of each HHS enterprise program providing case management services and our findings related to key features of these programs. The program review included the following sources: interviews with program managers or staff from each department, focus groups, telephone interviews with consumer advocates, and analysis of available expenditures and utilization data. The report finds that the HHS enterprise programs have different funding streams, reimbursement methodologies, eligibility requirements, requirements for case managers and administrative structures. The programs have developed separately over time in response to the needs of the consumers they serve, and to the demands of the funding mechanisms, which accounts for the variation between programs.

- *Review of stakeholder feedback received to date*: We have collected stakeholders' comments about optimizing case management through focus groups, advocate interviews and on-going telephone and online surveys.

- *Development of preliminary recommendations for improving the organization and delivery of case management services*: These preliminary recommendations, which were available for public comment in July and August of 2007, focus on the restructuring of case management and consumer-centered approaches with an emphasis on greater accountability and outcomes. In brief, our recommendations are:

    - Develop a single service definition and standardized provider qualifications applicable to all departments and programs.

    - Develop uniform protocols for screening, triage and referral to avoid duplication of services and to enhance access to services.

    - Integrate management information systems across the various departments.

- Develop a uniform reimbursement methodology that may allow HHSC to track and monitor provider performance and outcomes for individuals that receive case management services.

Navigant Consulting considers these recommendations consistent with the goals of Senate Bill 1188 and feasible from a regulatory and financial point of view.

We have also reviewed the use of cost containment practices within private and public health programs:

- *Utilization management* practices monitor resource allocation and consumption within private and Medicaid programs.
- *Case management* activities (under various names) generally have two key features: providing a connection between individuals and the system of publicly-funded services and supports, and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals.
- *Care coordination* programs coordinate a wide range of medical and social services within and outside individual managed care programs.
- *High-cost targeting* programs are implemented to contain costs incurred by individuals with multiple and complex needs. Disease management is the most common high-cost targeting program.
- *Provider incentives* programs, more prevalent within the commercial sector and Medicare programs than Medicaid, link reimbursement formulas to appropriate processes, quality, and outcomes.

In addition, we reviewed the Federal regulations and requirements for using 1915(c) and 1115 waivers:

- Section 1915(c) waivers provide the U. S. Secretary of Health and Human Services the authority to waive Medicaid provisions to allow states to deliver home and community-based services (HCBS) as an alternative to Medicaid reimbursable institutional services. Institutional services include, for example, services provided in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). 1915(c) waivers target particular populations with a variety of conditions and chronic disorders, such as physical disabilities, intellectual disabilities, developmental disabilities, acquired immunodeficiency syndrome (AIDS), acquired brain injuries and other forms of severe disability, including, to a limited extent, chronic mental illness. Federal regulation prohibits waiving off of nursing facilities

and ICFs/MR in the same 1915(c) waiver; therefore two waivers are required to serve both populations.[2]

- Section 1115 waivers provide the U. S. Secretary of Health and Human Services broad authority to authorize experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. States have used 1115 demonstrations to develop innovative programs for outreach and enrollment services, eligibility requirements, access, benefits, quality assurance, payment, safety net providers and special needs populations. The 1115 waiver Health Insurance Flexibility and Accountability (HIFA) initiative allows states to streamline benefits packages and create public-private partnerships to expand health care coverage for the uninsured by using existing Medicaid and SCHIP resources.[3]

Based on discussions we had with HHS enterprise representatives, who raised questions about options to enhance federal funding, we also reviewed the use of Title IV-E waivers to determine their applicability to implementation of case management waivers.[4] Title IV-E Child Welfare waivers permit states to use federal foster care funds with greater flexibility to improve outcomes for children. Title IV-E demonstration projects require system wide modifications to a comprehensive array of foster care services, not only case management. Title IV-E waiver authorization expired in 2007. No new waivers will be approved unless Congress reauthorizes these waivers in the future.

The remainder of this report includes the following:

- *Section III* – Provides background information on cost containment and quality practices as defined within the private and public sectors.
- *Section IV* – Provides background information on Federal regulations governing the 1115 and 1915(c) waivers and the scope of different waiver categories.
- *Section V* – Examines the feasibility of developing a 1915(c) or 1115 waiver to consolidate and integrate case management functions (i.e., utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures) implemented with respect to the Medicaid program.

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[2] *Code of Federal Regulations*, Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill.".

[3] The U.S. Department of Health and Human Services has invited states to participate in the Health Insurance Flexibility and Accountability demonstration initiative beginning August 4, 2001.

[4] United States Code, Social Security Act §§601-687, Subchapter IV, Chapter 7, Title 42, Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services, Part E-Federal Payments for Foster Care and Adoption Assistance. Available online: http://www.socialsecurity.gov/OP_Home/ssact/title04/0400.htm.

- *Section VI* – Discusses the feasibility of developing a Title IV-E Child Welfare waiver to optimize case management.

- *Section VII* – Presents the conclusion of the study.

A web-based version of this report was made available for review and comment in August 2007.

II. COST CONTAINMENT AND QUALITY PRACTICES

The RFP requested that we consider whether utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures implemented with respect to the Medicaid program should be combined within a single program. There are no standard definitions of these practices, and many of their features overlap. States and other payers often use the above terms interchangeably. Below, we provide a general description of these concepts.

Utilization Management

Utilization management practices monitor resource allocation and consumption within private and Medicaid programs. The Utilization Review Accreditation Commission (URAC) defines utilization management as "the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provision of the applicable health benefits plans."[5] Utilization management techniques are ubiquitous in the private sector and Medicaid managed care health plans.[6,7] The most common utilization management functions are:

- *Precertification* – Requires the approval of services before delivery. For Medicaid programs, precertification could be required for medical, long-term care, hospital services and behavioral health or pharmacy services.

- *Concurrent review* – Refers to the authorization of additional services and length of stay.

- *Retrospective review* – Assesses the medical necessity of admissions that were not subject to the precertification process to evaluate inappropriate utilization or quality of care issues.[8]

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[5] URAC, "What Is Care Management?" Available online at: http://www.urac.org/resources/careManagement.aspx.
[6] Alan Koike, et al., "Utilization Management in a Large Managed Behavioral Health Organization," *Psychiatric Services* (May 2000) 51(621-626).
[7] Bruce Landon and Arnold Epstein, "For-Profit and Not-For-Profit Health Plans Participating in Medicaid," *Health Affairs* (May/June 2001) 20:3(162-171).
[8] URAC, "What Is Care Management?" Available online at: http://www.urac.org/resources/careManagement.aspx.

Providers argue that utilization management limits their autonomy and places additional administrative burden on their practices. Insurance carriers, managed care plans and third-party payers endorse the practice as a tool to decrease the unnecessary and inappropriate use of health care services.[9]

Within the HHS enterprise, the case manager, programs and departments all provide some variation of utilization management activities.

Case managers have utilization management responsibilities, depending on the program's definition of case management. As described in Navigant Consulting's *Case Management Optimization Analysis of Current Case Management Systems Report*, case management services may include utilization management components such as developing and reviewing an individual's plan of care, prior authorizing services and reassessing the individual's need for services as necessary.

Currently, there is no central HHSC division that coordinates utilization management across programs and departments. Many programs independently perform utilization management functions. Below, we describe examples of the utilization management activities in each of the four HHS enterprise departments.

- *Department of Aging and Disability Services (DADS)* – Case managers develop plans of care and pre-authorize services. Case managers/supervisors and utilization review staff perform level of care, level of need and individual plan of care reviews. A utilization review committee performs nursing facility medical necessity determinations, and case managers perform reassessments to determine ongoing need for services and the continued eligibility for the services.

- *Department of Assistive and Rehabilitative Services (DARS)* – Division for Blind Services staff in local field offices and the Central Office in Austin monitor utilization of the products and services that are purchased for consumers in the Division of Blind Services.

- *Department of Family and Protective Services (DFPS)* – Child Protective Services uses a third-party contractor to perform regular utilization reviews of a child's authorized service level.

- *Department of State Health Services (DSHS)* – The Department requires contracted Mental Health Authorities to maintain a utilization management program that uses DSHS' approved utilization management guidelines for authorization, reauthorization, medical necessity, appeals, complaints and other standards. The Department's Children with Special Health Care Needs program, for example,

[9] Thomas M. Wickizer and Daniel Lessler, "Utilization Management: Issues, Effects and Future Prospects," *Annual Review of Public Health* (May 2002) 23(233-254).

monitors utilization for providers and consumers, and conducts reviews of medical necessity and provider payment accuracy.

Case Management and Care Coordination

Case management activities (under various names) generally have two key features: providing a connection between individuals and the services and supports they need, and assuring that these services meet reasonable standards of quality and lead to improved outcomes for individuals. In our earlier *Case Management Optimization Best Practices and Emerging Trends in Case Management Report,* we describe how case management programs can vary across payers and programs. And, in our *Case Management Optimization Analysis of Current Case Management Systems Report*, we describe how case management services differ across the various Texas programs under study.

Care coordination programs coordinate a wide range of medical and social services. It is very difficult to distinguish "care coordination" from case management." In fact, in our *Case Management Optimization Recommendations for Improving Texas Case Management Delivery Report*, we recommended that Texas consider renaming all current activities that fall within the rubric of "case management", "service coordination." We made this recommendation for a number of reasons, including the concern that we have heard and read in research that individuals do not want to be referred to as "cases" to be managed.

High-Cost Targeting Programs

High-cost targeting programs are implemented to contain costs incurred by individuals with multiple and complex needs. Disease management is the most common high-cost targeting program but is outside the scope of this study. We have not heard any Department staff, consumers, providers, or other stakeholders refer to any high-cost targeting programs in the HHS enterprise programs we reviewed.

Provider Incentive Programs

Provider incentives programs, more prevalent within the commercial sector and Medicare programs than, at least until very recently, Medicaid, link reimbursement to appropriate processes, quality and outcomes. Similar to high-cost targeted programs referenced above, we have not heard any Department staff, consumers, providers, or other stakeholders refer to any provider incentive programs in the HHS enterprise programs we reviewed. Nevertheless, there may be opportunities in the future for HHSC to develop provider incentive programs as they consider restructuring the reimbursement, as further recommended in our *Case Management Optimization Recommendations for Improving Texas Case Management Delivery Report*.

In summary, we believe that case management and service coordination are one and the same matter; utilization management is provided in conjunction with case management services at several levels; and high-cost targeting and provider incentives are not currently part of the case management services included in our review. The recommendations we have provided to

optimize case management set the foundation, however, for implementing more consolidated and uniform high-cost targeting and provider incentives.

III. SECTION 1915(C) AND 1115 MEDICAID WAIVERS

The Social Security Act waivers and demonstration programs provide states flexibility in operating the Medicaid program. Each category of waiver and demonstration programs (e.g., 1915(c), 1915(b) and 1115) has a distinct purpose, and distinct requirements.[10] We discuss in this section of our report 1915(c) and 1115 waivers, as the scope of our work does not cover services provided by Texas Medicaid included in the state's 1915(b) waiver programs.

Section 1915(c) Waivers

Section 1915(c) allows states to deliver home and community-based services (HCBS) as an alternative to Medicaid reimbursable institutional services (i.e., services provided in a hospital, nursing facility or ICF/MR).[11] Through 1915(c) waivers, states can target particular populations. Consequently, unlike optional state plan benefits, waivers do not require that services be made available to all categorically or medically needy groups. Historically, states developed waivers to target the aged and disabled and those with developmental disabilities. More recently, these waiver programs have evolved to target Medicaid-eligible persons with a variety of conditions and chronic disorders, such as physical disabilities, acquired immunodeficiency syndrome (AIDS), acquired brain injuries and other forms of severe disability, including, to a limited extent, chronic mental illness. Section 1915(c) waivers also allow states the opportunity to make available a wide range of non-medical, personal assistance services, including case management, personal care services, homemaker and chore services, adult day care, transportation and respite and companion services. To date, however, CMS' policy is that it will not approve cross-disability 1915(c) waiver applications.

When developing a 1915(c) waiver, states must prove that the cost of providing waiver services to a target population is not higher than it would be to provide the same care in an institutional setting. Therefore, 1915(c) waivers allow states to use a wide array of cost-containment strategies to meet the budget neutrality requirement, including: limiting financial and functional eligibility, enrollment limits and waiting lists. All states, except Arizona, have multiple HCBS waivers for populations at risk of institutionalization. Texas currently operates nine 1915(c) waivers.

[10] States may request Section 1915(b) to operate programs that impact the delivery system of some or all individuals eligible for Medicaid in a state by mandatory enrollment in managed care or by creating a "carve out" delivery for specialty care, such as behavioral health.

[11] CMS, "HCBS Waivers-Section 1915(c)". Available online: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp.

Section 1115 Waivers

Section 1115 of the Social Security Act provides the U.S. Secretary of Health and Human Services broad authority to authorize experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.[12] Section 1115 also provides the U.S. Secretary of Health and Human Services the authority to waive certain statutory requirements in Section 1115(a) of the Social Security Act for conducting these projects without congressional approval. Projects authorized under section 1115 must demonstrate and evaluate a policy or approach that has not been tested on a large scale. States have used 1115 demonstrations to develop innovations in outreach and enrollment, eligibility requirements, access, benefits, quality assurance, payment, treatment of safety net providers and programs for special needs populations.

CMS categorizes 1115 waiver programs as follows:

- *Comprehensive demonstrations*: These waiver programs provide a broad range of services that are generally available statewide.

- *Family planning demonstrations*: These waiver programs expand family planning services beyond the standard Medicaid 60-day postpartum period, to include individuals leaving Medicaid for any reason and to individuals who have incomes above Medicaid's income eligibility limit(s). For example, Florida extended eligibility for family planning for two years to childbearing-age women with incomes at or below 185 percent of the Federal Poverty Level (FPL).

- *Health Insurance Flexibility and Accountability Initiative (HIFA) waivers*: Implemented in 2001, this waiver initiative encourages states to increase the number of individuals with health insurance coverage by integrating SCHIP and Medicaid funding and maximizing the use of private insurance for populations with incomes below 200 percent of the FPL. Combined HIFA waivers allow the state to finance changes to its Medicaid Program using unspent SCHIP Funds. However, the Deficit Reduction Act prohibits the approval of new waivers that allow the use of federal SCHIP funds for coverage of non-pregnant childless adults.

- *Pharmacy plus demonstrations*: The 1115 pharmacy plus demonstration allow states to provide prescription and over-the-counter drug coverage to Medicare beneficiaries and/or people with disabilities with incomes at or below 200 percent of the FPL who are not eligible for comprehensive Medicaid benefits available under the State's plan.

- *Specialty services and populations demonstrations*: These waivers generally provide cash to enrollees to directly arrange and purchase the services that best meet their needs. These waivers also include programs to provide pharmacy benefits to

[12] CMS, "Research and Demonstration Projects-Section 1115". Available online: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp.

individuals with specific conditions, like HIV/AIDS, to access drug regimens before they become symptomatic and disabled.[13]

The Centers for Medicare and Medicaid Services does not have a standardized application form for 1115 waivers, however, CMS specifies that a demonstration proposal typically discusses the environment, administration, eligibility, coverage and benefits, delivery system, access, quality, financing issues system support, implementation timeframes and evaluation and reporting. CMS does not have a specific timeframe to approve, deny or request implementation. The review and approval process could take between two to twenty five months, with a median waiting time of six months. In addition, there is no guarantee that CMS will approve an 1115 waiver. Over the years, CMS has denied numerous 1115 waiver applications.

Section 1115 waivers have a five-year lifespan and the state can extend the program with CMS' approval. The state must demonstrate that the proposed program's expenditures will not exceed what would have been incurred without the demonstration. Budget neutrality does not have to be achieved in each individual year of the program, but must be demonstrated cumulatively for the project's five year lifespan. States have demonstrated budget neutrality for their applications using managed care savings, reallocation of disproportionate share of hospital funds, pay now, save later estimates, and through controlling enrollment and benefits, as well as through cost sharing strategies.[14] The general assumption of these strategies is that covering more uninsured persons under the waiver program will offset costs incurred within different Medicaid budget categories (e.g., disproportionate share hospital funds, high-cost intensive care).[15]

Although an 1115 waiver gives the states flexibility to design innovative demonstration programs and to integrate different populations and services, the development of the waiver requires a significant amount of time and administrative effort. Most often, 1115 waivers increase the complexity of the Medicaid program and the budget neutrality requirement limits the state's access to open-ended federal financing and makes the state responsible for all costs that exceed the negotiated cap.

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[13] Congressional Research Services, *"Medicaid and SCHIP Section 1115 Research and Demonstration Waivers"* (CRS Report for Congress, March 17, 2007). Available online: http://opencrs.cdt.org/document/RS21054.

[14] Charles Milligan, "*Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage"* (Academy for Health Services Research and Health Policy, May 2001), Available online: www.statecoverage.org.

[15] Disproportionate Share Hospital Funds are special payments Medicaid makes to hospitals that treat a disproportionately high number of low-income patients.

IV. FEASIBILITY OF AN 1915(c) OR 1115 WAIVER

This Section describes why the development of a 1915(c) or 1115 waiver to combine utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures is neither feasible nor necessary.

A waiver that would encompass the functions listed above would include consumers with a wide range of disabilities. For example, DADS consumers may have mental retardation or developmental disabilities and DARS consumers may be blind or visually impaired. The Centers for Medicare and Medicaid Service's policy is to reject cross-disability 1915(c) waivers, and we anticipate they will use the same policy in evaluating cross-disability 1115 waivers. As such, securing CMS' approval is likely not feasible unless CMS reverses its policy on cross-disability waivers.

As demonstrated within Section III, both 1915(c) and 1115 Medicaid waivers have broad scopes and can include a wide range of Medicaid services. A 1915(c) waiver encompassing utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures would be restricted only to programs serving populations at risk of institutionalization. Based on our review of existing waivers, it would be unusual to have a waiver that covers only the case management and related functions associated with the delivery of home and community-based services which may include respite care, nursing services, personal assistance services, day habilitation services, speech, physical and occupational therapy services and other services. Given the restrictions imposed by the 1915(c) waiver regulations and CMS policies, such a waiver would not include all of the populations in the HHS enterprise.

An analysis of approved 1115 waivers show that these waivers either provide a broad range of services that are generally available statewide, or develop strategies to cover more uninsured populations. The development of an 1115 waiver that would consolidate only quality and cost control strategies is not consistent with either of these approaches. Additionally, to consolidate all services provided in conjunction with case management services across all agencies and programs, HHSC would have to expend significant resources to reform financing, staffing and service delivery strategies across the HHS enterprise. HHSC would also need to find a strategy to demonstrate budget neutrality and be prepared to assume all costs that exceed the Federal cap negotiated under the 1115 waiver. This effort would require substantial additional administrative burden and would likely require creating an organization that would be responsible for the consolidated activities. The functions of this organization would need to include:

- Evaluating the effectiveness and efficiency of existing quality and control measures in the HHS departments and programs
- Assessing the need for developing additional cost control measures such as provider incentives and the impact of these measures on providers and consumers

- Developing and implementing a consolidation strategy for all quality and control measures to be implemented across agencies and programs

It does not appear that consolidating utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures across all programs would necessarily result in optimization of these functions. To date, HHSC's experience with the Consolidated Waiver Program (CWP) has been inconclusive in regards to whether or not a single program is administratively efficient and effective. The CWP serves individuals who would be eligible for the following waiver programs: Medically Dependent Children Program, Community Living Assistance and Support Services waiver, Home and Community-Based Services waiver, Deaf-Blind with Multiple Disabilities waiver and the Community Based Alternatives waiver. This pilot program is limited to serving 200 individuals in Bexar County. Department of Aging and Disability Services staff offer case management for program participants and the program receives Medicaid administrative match (50/50) for case management services. Costs for case management are claimed as administrative costs.[16] In 2003, HHSC conducted an evaluation of the CWP and concluded that "program data is inconclusive whether a single program is administratively efficient and effective." HHSC recommended continuing the existing pilot for a more definite evaluation and policy assessment.

The benefits of using a 1915(c) or 1115 waiver to combine utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures are far outweighed by the challenges, especially as we believe a federal waiver is not necessary for HHSC to achieve case management optimization and the consolidation of utilization management, high-cost targeting, provider incentives and other quality and cost control measures.

Navigant Consulting's recommendations, as outlined in the *Case Management Optimization Recommendations for Improving Texas Case Management Delivery Report*, promote the integration of case management and care coordination without the use of a waiver. They also provide the foundation for further consolidation of utilization management, high-cost targeting, provider incentives and other quality and cost control measures across the HHS enterprise. Below we provide an overview of the recommendations and how they support consolidation:

- *Developing a single service definition for case management and care coordination* – Provides a common terminology across the HHS enterprise for case management and care coordination services.

- *Developing standardized provider qualifications applicable to all departments and programs* – Allows providers to be compared and assessed across the HHS enterprise to identify areas for consolidation.

[16] The administrative match refers to the Federal financial participation for allowable costs that the Medicaid or other agency incurs in the activities arising from the administration of a state's Medicaid program.

- *Creating uniform protocols for screening, triage, and referral to avoid duplication of services and enhance access to services* – Decreases costs associated with duplication efforts and enhances service coordination efforts through improved communication among different service entities.

- *Integrating management information systems across various departments* – Allows HHSC to standardize utilization, outcomes and financial data and reports across the health and human services enterprise.

- *Developing a uniform reimbursement methodology that will allow HHSC to track and monitor provider performance and outcomes for individuals that receive case management services* – Provides the information necessary for HHSC to determine how to implement further consolidation of utilization management and provider incentive practices.

These recommendations facilitate the consolidation of case management and care coordination functions and include other quality and cost control measure (e.g., more consistent educational requirements for case managers, a uniform reimbursement system). The additional quality and control measures provide HHSC with tools to more effectively manage utilization across programs and departments.

V. TITLE IV-E CHILD WELFARE WAIVER DEMONSTRATION PROJECTS

Based on discussions we had with HHS enterprise representatives, who raised questions about options to enhance federal funding, we also reviewed the use of Title IV-E waivers to determine their applicability to implementation of case management waivers. A Title IV-E Child Welfare waiver permits the state to use federal foster care funds with greater flexibility in order to improve outcomes for children. Title IV-E waiver authorization expired in 2007. No new waivers will be approved unless Congress reauthorizes these waivers in the future.

VI. CONCLUSION

This report discusses the feasibility of combining under a single 1115 or 1915(c) federal waiver utilization management, case management, care coordination, high-cost targeting, provider incentives and other quality and cost control measures. Based on our analysis of case management best practices, cost-containment strategies, and federal regulations for 1915(c) and 1115 waivers, we concluded that developing a new waiver to consolidate these features is neither feasible, nor necessary. As part of our recommendations, we developed strategies to consolidate case management and care coordination services that do not necessitate developing a new waiver and that provide the foundation for the consolidation of other functions. These strategies support HHSC's objectives without the administrative and financial limitations associated with Medicaid waivers.