



North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

May 8, 2003

The Honorable Edd Nye, Co-Chair
House Appropriations Subcommittee on Health and Human Services
639 Legislative Office Building
Raleigh, NC 27603-5925

Dear Representative Nye,

Pursuant to Session Law 2002-126 (SB 1115, Section 10.14.a), I am forwarding the final report on the Department of Health and Human Services' review of Medicaid funded case management services and plan for a reduction in case management expenditures for the 2002-2003 State fiscal year. The report describes the research completed and steps taken by the Department, as well as further plans for addressing the requirements of this legislation. I am pleased to provide this report to you.

If you have any questions or need additional information, please contact Jim Bernstein. He can be reached at 715-4127.

Sincerely yours,


Carmen Hooker Odom

Attachment

cc: Senate Appropriations Committee on Health and Human Services
House Appropriations Subcommittee on Health and Human Services
Fiscal Research Division
Legislative Library (2 copies)
Lanier Cansler
Jim Bernstein
Allyn Guffy
Carol Shaw
Daphne Lyon
Rob Lamme

April 11, 2003

**Reduction of Medicaid Program Expenditures
for Case Management Services
for Adults and Children for SFY 2002 - 2003**

Senate Bill 1115, Section 10.14(a)

As required by Section 10.14(a) of Senate Bill 1115, the Department of Health and Human Services has undertaken a review of all case management services reimbursed by the Medicaid program in order to determine how to allocate a \$ 7.7 million reduction in Medicaid expenditures for case management services for adults and children for the 2002 -2003 State Fiscal Year. This review has built upon the ongoing work of Department staff assigned to analyze all Medicaid funded case management services and make recommendations to the Secretary for actions that would further these programs' ability to improve quality and cost-effectiveness. The review also considered the following issues, as required in S.B. 1115:

1. Elimination of duplicative case management services.
2. Consolidation of similar case management services.
3. Provision of only one case manager per family reimbursed through the Medicaid program, when feasible.
4. Equitable allocation of reductions in case management services reimbursed by Medicaid among the different programs that provide case management services.
5. Identification of the children and adults with the greatest management needs to determine how to allocate reductions and remaining resources.
6. Reductions in administrative costs associated with providing case management services reimbursed by Medicaid.
7. Reductions in reimbursement to case management service providers.

This report will discuss the Department's efforts to date to facilitate improvements in quality and cost-effectiveness, as well as outline plans for achieving the requisite reduction in Medicaid expenditures for case management services in SFY 2002 -2003.

Overview of Medicaid Funded Case Management Programs

In June 2002, under the direction of the Assistant Secretary for Health, a work group of staff from each of the Department's Health Divisions and from the Division of Social Services was formed to conduct a comprehensive study of Medicaid funded case management services. The services being studied are case management provided under the Community Alternatives Programs for Disabled Adults (CAP/DA), Children (CAP/C), AIDS patients (CAP/AIDS), the Mentally Retarded and Developmentally Disabled (CAP/MR-DD); HIV Case Management; Case Management Services provided by Area Mental Health Programs; Maternity Care Coordination (MCC) Program; Maternal Outreach Worker (MOW) Services; Child Service Coordination (CSC); and Adult Care Home Case Management Services (ACH/CMS). As part of this effort, DHHS staff surveyed each division to identify, catalogue, and describe in detail the

populations served, models for service delivery, administrative structure and rules, finance structure and costs, and expected outcomes from each Medicaid funded case management program. The results of this comprehensive survey are currently being compiled and analyzed; however, the staff's preliminary observations are worth noting.

Medicaid case management services are defined as activities which assist individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Because research has demonstrated the connection between case management and utilization of medical and support services, states such as North Carolina have for many years employed case management programs as an effective strategy for reducing Medicaid recipients' unmet needs, improving utilization of ambulatory services, and avoiding costly institutional care. The program structure for North Carolina's coverage of case management services mirrors its Medicaid fee-for-service program as a whole. It is best described as a number of parallel silos in which each individual program has its own processes for outreach, assessment, care planning; follow-up procedures; requisite forms and documentation; regulatory requirements; and financing structures. This programmatic complexity is in large part due to the disparate client populations being served (e.g., pregnant women and infants, HIV/AIDS patients, medically-fragile children, the frail elderly, the mentally ill) and specialization of those who serve these populations within the divisions of the Department.

The specific activities included in each case management program is further contingent upon the federal basis for the State's coverage of the service (i.e., administrative, targeted, or waiver case management). An administrative case management service may be provided as a function necessary for the proper and efficient operation of the Medicaid State Plan. Adult Care Home Case Management Services (ACH/CMS) is an example of administrative case management. Under ACH/CMS, a case manager from the county department of social services or area mental health program performs periodic utilization review and prior approval functions on behalf of the State, specifically authorizing and re-authorizing "enhanced" payments for personal care services performed by an adult care home for a "heavy care" resident. Targeted case management services such as Maternity Care Coordination (MCC) or HIV Case Management are provided for a specific subset of Medicaid recipients identified by their age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination thereof, and may be extended statewide or limited by geographic or political boundaries. Case management services may also be provided as part of a Home and Community-Based Services (HCBS) Waiver in which the Centers for Medicare and Medicaid Services (CMS) grant a waiver to the State of specific requirements for coverage under the Social Security Act. The case management performed for participants in the Community Alternatives Program for Disabled Adults (CAP/DA) is a waiver case management service. The CAP/DA case manager acts as the State's gate-keeper to assure that in-home services are adequate to meet the needs of the client and cost-effective in comparison to institutional care.

Eliminate Duplication, Consolidate Similar Services, and Provide One Case Manager Per Family

Public assistance clients are often served by a variety of public health, home health, social services, and behavioral health professionals with similar job titles (e.g., care managers, care planners, care coordinators, case workers, case managers). This can result in the appearance of

redundancy; however, these individuals' primary functions and the funding sources for these rarely overlap in practice. In October 2002, DHHS staff initiated a comprehensive analysis of 5 years of utilization and expenditure data for Medicaid funded case management programs in order to document any inappropriate duplication. Analysis of two data runs for SFY 2001 completed thus far reveals that only a few Medicaid recipients actually have more than one case manager. Of all case management expenditures for SFY 2001, about 23% were paid for services provided during a single month to two or more recipients residing in the same household, and only 2% of expenditures paid were for individuals who received more than one case management service. Medicaid recipients eligible for case management and their families often have quite complex medical and social situations that require the expertise of different types of case managers in order to meet their needs. In addition, in certain circumstances such as when a client is transitioning from one program to another or has particularly complex needs, the involvement of more than one case manager for a time may be appropriate. Further analysis is needed to determine the appropriateness of all the incidences that were identified.

With very few exceptions, Medicaid's current policies for coverage of case management services (e.g., the Community Alternatives Programs, HIV Case Management, and Mental Health Case Management Services) require providers to coordinate services provided to multiple family members in the same household, such that only one case manager provides the service for all of the clients in the home. Undoubtedly, condensing similar case management activities, when feasible, for a family that has multiple family members eligible for these services would also likely save additional state dollars. Because many of the tasks performed as MCC are the same or very similar to Maternal Outreach Worker (MOW) services and Child Service Coordination (CSC), the Division of Public Health (DPH) is developing a Family Care Coordination (FCC) model whereby one case manager would provide service to the family from pregnancy through the child's fifth year. Specific details of how this FCC model would be piloted, where and when it would be piloted, and what, if any, savings could be realized have yet to be determined.

In addition, as a part of the mental health system reform efforts currently underway in North Carolina, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) in coordination with the Division of Medical Assistance (DMA) has proposed changes in how the models and functions of case management services provided by area mental health programs and CAP/MR-DD case management are defined, to differentiate between various functions bundled within the existing definition. This delineation, which will become effective October 1, 2003, will include:

- Advocacy and monitoring of the person-centered planning process;
- Case management activities becoming more family focused rather than client specific; and
- Coordination among multiple agencies' roles in plan implementation.

Obtaining additional information, at the local level, will be necessary in order to determine the critical components of each Medicaid case management program, to determine if integrating any functions would be feasible and cost effective, and to prioritize limited resources. Based on anecdotal information from Division program staff, it appears that some consolidation of Medicaid case management services is occurring at the local level without a State mandate. Regardless of the broad range of client populations that are being served with these programs,

service delivery, service coordination, and administration is often provided by the same agencies and with the same case managers. DHHS staff plan to conduct focused in-depth interviews with local agencies and providers responsible for service delivery in 2003 to better understand how the service models are applied at the local level and what similarities and variation exists among and between local agencies and across various counties. DHHS staff will evaluate care management activities, relationships between care managers and service providers, and level of local interagency coordination to determine when integrating case management services or functions would be appropriate.

Identify Clients with the Greatest Needs and Equitably Allocate Reductions and Resources

Another objective of the Department's analysis of Medicaid utilization and expenditure data has been to identify those recipient populations most likely to need the services of a case manager (e.g., ranking high risk/high cost to low risk/low cost) and develop risk priorities. Department staff plan to use RiskSmart software, developed by DxCG, Inc., in the coming months to evaluate Medicaid medical and pharmacy claims information and stratify client populations into risk groups and predicted cost categories. This analysis will be helpful in predicting future costs and will facilitate the equitable allocation of future reductions and remaining resources.

Another area that has previously been largely unexplored is the use of information technology as a tool to increase efficiency and lower costs by improving case managers' productivity and reducing administrative costs. Department staff are at present analyzing the possibility of using an automated Universal Risk Assessment Tool to triage clients to the most appropriate source for case management services within the community and help target services to those most in need.

Additionally, the mental health system reforms will require area mental health programs to re-examine all clients with regard to meeting specific qualifications for services within the three broad target populations (i.e., mental illness, developmental disabilities, substance abuse). As a part of these efforts, DMH/DD/SAS provided area mental health programs, in the July 2002 State Plan: Blue Print for Change, with more discreet definitions for identifying clients within these target populations who would be considered as having the greatest need. Further clarification was given in an October 2002 Communiqué regarding target populations. The area mental health programs will, in turn, no longer provide services to all applicants nor provide services on a "first come first served" basis. The populations that have been identified, thus far, as requiring the services of a case manager are participants in the CAP/MR-DD waiver program; "Olmstead eligible" individuals (i.e., clients eligible for de-institutionalization); and children served in the Comprehensive Treatment Services Program (CTSP). Achieving significant changes in the composition of these target populations will likely be a protracted process. Anyone currently receiving Medicaid case management from an area mental health program whose service would be discontinued may file an appeal, which would then require that the service be continued until the appeal is settled. Area mental health programs are already working to transition those clients who they anticipate will not be eligible to continue to receive services and assure that sufficient support is available within the community to alleviate the need for ongoing case management.

DPH has also proposed a plan for targeting MCC and MOW services to pregnant women with the greatest need. At present, the MCC program is available to all Medicaid eligible pregnant women through local health departments and a select group of community, rural, and migrant

health centers and private providers. MOWs work under the care plan of the MCCs in approximately 60% of North Carolina counties to provide additional service support for pregnant and postpartum (1-year) women. DPH proposes the following changes to these programs in order to focus resources and efforts to those individuals with the greatest need, along with ensuring that the needs can be adequately addressed and/or impacted by the MCC/MOW program. Medicaid eligibility will no longer be the sole determining factor for MCC/MOW service provision. In the future, all pregnant women will complete a self-screen, focusing on such issues as access to care (e.g., transportation, child care); living conditions (e.g., homelessness, stability); substance abuse; domestic violence; depression; and pregnancy intendedness. An MCC will review the results of the screening with the client and determine whether the client needs only basic written information or a more in-depth assessment. Clients who need only basic written information will be given materials and contact information in case their circumstances change.

The assessment will become the primary point of entry into the MCC/MOW program for participating clients. Utilizing pathways of care, the assessment will drive the plan of care for the client. Providers will conduct regular coordination conferences to ensure that issues are being appropriately addressed. A second point of entry into the program will be through provider referral. If a provider determines that the client's circumstances have changed, he can refer the client to the MCC for a re-screen and assessment if necessary. Providers will also be encouraged to merge all of the client's medical records into a single complete record. This system will allow for the following:

- Target services to those with the greatest need that can be impacted by the MCC/MOW program.
- Decrease redundancy for the client and providers. Information will be shared by providers. Therefore, questions will not need to be repeated.
- Increase efficiency by having the client complete a self-screen.
- Increase coordination among providers involved in care of these clients.
- Build on tools and processes already in development in counties served by the Baby Love Plus program (federal perinatal disparity grant in 14 counties).

DPH plans to pilot this concept in 10 counties, make any needed adjustments, and then expand statewide. This initiative will undoubtedly require extensive provider training, but the expected result is a better quality, streamlined program for pregnant women most in need.

Reduce Administrative Costs Associated with Providing Case Management Services

Between September and November 2002, DHHS staff surveyed and conducted focused in-depth interviews with the individual Division staff responsible for administration of each case management program to understand state administrative responsibilities and associated costs. At the state level, administrative costs for these programs are minimal. Program management and oversight is typically provided by one or two individuals as a small part of their overall responsibilities. For example, at the state level, only 10% of one Full Time Equivalent (FTE) position at the Division of Social Services and about 33% of one FTE at DMA are required to administer the ACH/CMS program. Administrative costs associated with providing case management services are also reported to be low on the local level. The Department intends to achieve additional cost savings and program efficiencies, as well as reduce the administrative

burden of service providers, by examining the administrative functions of case managers under each program and eliminating unnecessary activities whenever possible. One area in which this is already occurring is within the state's mental health system. As part of the mental health reform efforts and transition to local management entities, DMH/DD/SAS is redesigning the case management structure within all area mental health programs. In response to concerns voiced by area mental health programs, DMH/DD/SAS has studied the administrative functions associated with providing case management services, particularly the paper work required under the CAP/MR-DD program, and has made significant reductions in the expectations placed on waiver case managers. This process will be ongoing over the next year with significant transition during the following fiscal year.

Reduce Reimbursement to Case Management Service Providers and Restructure Financing for Case Management to Save State Dollars

Medicaid case management programs, except ACH/CMS, are reimbursed as a fee-for-service, with the rates established and periodically adjusted by DMA through a cost finding process. County departments of social services and area mental health programs that provide ACH/CMS are reimbursed for their costs under a contractual arrangement. However, a cost survey performed in 2001 by DMA revealed that at least for CAP/DA, CAP/C, and CAP/AIDS, the reimbursement rate paid at that time for case management performed for participants in those programs, and the same rate in effect today, is well below the median of the cost of providing these services in North Carolina. Because of expectations of low reimbursement and the significant challenges associated with serving patient populations with serious medical and social needs, provider agencies are often reluctant to participate in the Medicaid case management programs. Any significant rate reduction for the majority of Medicaid case management programs will likely diminish provider participation even further and cripple service capacity, especially for poorer counties that cannot afford to subsidize the loss through the use of local funding resources.

There has not previously been a comprehensive review of Medicaid financing opportunities that could in-part offset state only expenditures. DHHS staff are currently exploring potential areas for policy and procedural changes which could further reduce or at least maintain state costs related to case management at current levels. The unbundling of Medicaid billing for the MCC and CSC programs that was effective October 1, 2002 has resulted in approximately \$1.25 million reduction per quarter in State since then, and at current rates of payment, this would result in a savings of approximately \$5 million by the end of the FY. Service impact is not known at this time, but anecdotal data suggests that a significant number of providers in rural areas are very concerned that programs cannot be maintained at revenue levels being generated under the new billing scenario. Clearly a significant savings will be realized from these changes in MCC and CSC, but the level of decrease referenced above may not be sustainable once the transition of the unbundling process is stabilized and provider experience with this methodology is gained.

With the resolution, in December 2002, of the court injunction against the July 2002 rate reductions for CAP-MR/DD case management, DMA and DMH/DDSAS engaged in a formal process to: a) review the non-essential administrative duties that had been added to CAP case manager responsibilities and b) pursue using the reduction of responsibilities as a foundation for

re-examining the monthly case rate paid for CAP-MR/DD case management. An initial review and reduction of case management administrative duties was reached in September with more elements to be considered in light of roles clarification pursuant to State Reform. A DMA Cost Committee meeting with relevant stakeholders was held in March 2003, resulting in a recommendation of a reduction in the CAP-MR/DD case management rate from \$509 per case per month to \$338.45 per case per month. Prior to submitting the new rate to the Centers for Medicare and Medicaid Services (CMS), the Department will review cost findings for the remaining functions associated with the service. The Department is working towards having the new rate, approved by CMS, to be effective by July 1, 2003. The recommended rate (\$338.45) will yield a savings of \$170.55 per case per month. This amount multiplied by the number of current waiver recipients (5,780) would result in an annualized reduction in expenditures for CAP-MR/DD case management of approximately \$11,829,348. In addition, DHHS staff have identified some potential opportunities for drawing down a larger federal match for case management services through alternative financing arrangements, such as claiming a larger 75% federal and 25% state match for administrative case management activities provided for children served by area mental health programs under the Early Intervention program. The amount of any potential savings that could be realized with this change has not yet been established.

Conclusions

S.B. 1115, Sec. 10.14(a) requires the Department to reduce Medicaid program expenditures for case management services for adults and children for the 2002 – 2003 State fiscal year by \$7,716,342. The legislation also requires the Department in determining how to allocate the reductions to consider the issues of eliminating duplicative case management, consolidating similar services, providing one case manager per family when feasible, equitably allocating reductions among case management programs, identifying children and adults with the greatest case management needs, reducing associated administrative costs, and reducing reimbursement to providers. Assuring that a Medicaid reimbursed service is efficiently delivered, cost effective, and the most appropriate means for meeting the needs of the recipient are basic tenets of the Medicaid program and fundamental to the Department's mission. The cost savings associated with changes in policy and procedures for case management coverage and reimbursement that are already underway and those to be initiated by the Department later this year, and described herein, along with Medicaid expenditures for case management services being below budgeted levels during SFY 2002 - 2003, are expected to be more than sufficient to offset the \$7.7 Million reduction in expenditures for case management as required in S.B 1115.