

Joint Legislative Oversight Committee
on Mental Health, Developmental
Disabilities, and Substance Abuse
Services



Case Management for Persons
with MH/DD/SA

October 14, 2009

Legislation

- **Section 10.68A (a) (10) states that:** *The Department of Health and Human Services shall develop a plan for the consolidation of case management services. The plan shall address the timeline and process for implementation, the vendors involved, the identification of savings, and the Medicaid recipients affected by the consolidation. Consolidation under this subdivision does not apply to HIV case management. By December 1, 2009, the Department shall report on the plan to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.*

The Process

- ❑ A public forum was held – over 300 people attended.
- ❑ A work group was formed consisting of providers, family/recipients, other DHHS divisions, local Health Depts., local DSSs, LMEs and other interested parties.
- ❑ Agendas and call-in number was posted on the DMA website. Minutes and handouts were posted to the website.
- ❑ The group examined definitions, functions, administrative rules, documentation, qualifications of staff and providers, rates and impact on indigent care and other service delivery
- ❑ The draft proposals were distributed and posted. Final meeting is scheduled to discuss feedback received and next steps

Goals and Outcomes

Recipient Goals/Outcomes

- ❑ The recipient must be the center of our care instead of having case management done on a program specific basis.
- ❑ The recipient will have timely and uncomplicated access to care via “no wrong door” policy.

Goals and Outcomes cont'd

Case Manager Goals/Outcomes

- ❑ Increase quality and continuity of care of recipients through effective and efficient case management including simplifying and eliminating ineffective administrative processes where allowed by regulations.
- ❑ Implement client specific outcomes which address all identified needs.
- ❑ Decrease 'silo' case management
- ❑ Maintain disability/need specific expertise of the case manager.
- ❑ Case managers shall receive training to promote the highest quality possible and to insure the prevention of substandard service delivery.
- ❑ Develop professional standards for case managers.

Goals and Outcomes cont'd

System Goals/Outcomes

- ❑ Simplify the maze of the various types of case management services and systems for families and recipients.
- ❑ Eliminate duplication of functions and increase coordination/integration across case management functions to eliminate unnecessary use of Medicaid and other publicly funded services.
- ❑ Reduce costs or potential cost increases in the various covered benefit categories of Medicaid
- ❑ Support the development of interoperable medical record systems that support collaboration across the continuum of care.
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Purpose for Consolidating CM

- ❑ Increase quality and continuity of care
- ❑ Person centered
- ❑ Eliminate duplication
- ❑ Decrease 'silo' case management
- ❑ Reduce costs as a result of better coordination and quality care

Case Management

- ❑ Services that assist individuals in gaining access to needed medical, social, educational, and other services.
- ❑ Consists of 4 federally defined functions:
 - assessment,
 - development of care plan,
 - referral, and
 - monitoring and follow-up
- ❑ Optional Medicaid service
- ❑ CAP waivers require case management services

Care Management

- ❑ Addresses programmatic and preventive services needs of population
- ❑ Outcome-focused
- ❑ Uses data to monitor population and service delivery
- ❑ Uses systems, incentives, and information to improve care and manage medical/social/ behavioral health conditions more effectively

Expenditures in SFY 2009 (CM in Enhanced MH/SA and Community Support are estimates)

Summary of Case Management and Related Services, Dates of Service in SFY 2009

| Program | SFY 2009 | | | | | | Amount Paid for Case Management | |
|--------------------------------------|---------------------|--|--------------|-----------------------|-------------------|----------------------------|---------------------------------|----------------------|
| | Distinct Recipients | Distinct Recipients in CCNC ⁴ | CCNC Percent | Paid | Units | Estimated Total Cost of CM | Federal 64.46% | State & Local 35.54% |
| <i>CAP/C CM (per 15 min)</i> | 765 | 438 | 57.3% | \$ 1,418,611 | 95,223 | | \$ 914,437 | \$ 504,174 |
| <i>CAP/C CM (per month)</i> | 230 | 76 | 33.0% | \$ 657,000 | 1,752 | | \$ 423,502 | \$ 233,498 |
| <i>CAP/DA Case Mgmt</i> | 13,278 | 2,764 | 20.8% | \$ 24,705,273 | 1,691,109 | | \$ 15,925,019 | \$ 8,780,254 |
| <i>CAP/Choice Care Advr</i> | 63 | 27 | 42.9% | \$ 129,649 | 8,503 | | \$ 83,572 | \$ 46,077 |
| <i>CAP/MRDD Waiver TCM</i> | 10,137 | 5,580 | 55.0% | \$ 38,686,410 | 1,875,280 | | \$ 24,937,260 | \$ 13,749,150 |
| <i>DD Targeted CM</i> | 8,960 | 4,881 | 54.5% | \$ 24,401,164 | 1,188,048 | | \$ 15,728,990 | \$ 8,672,174 |
| <i>At Risk Case Mgmt¹</i> | 5,008 | 2,099 | 41.9% | \$ 3,445,246 | 357,006 | | \$ 3,445,246 | |
| <i>HIV Case Mgmt</i> | 2,485 | 1,429 | 57.5% | \$ 5,449,188 | 396,244 | | \$ 3,512,547 | \$ 1,936,641 |
| <i>Child Svcs Coord</i> | 18,633 | 16,292 | 87.4% | \$ 9,560,371 | 440,057 | | \$ 6,162,615 | \$ 3,397,756 |
| <i>Maternal Care Coord</i> | 28,690 | 10,538 | 36.7% | \$ 13,171,818 | 450,770 | | \$ 8,490,554 | \$ 4,681,264 |
| <i>MaternalOutreachWrkr</i> | 2,662 | 1,779 | 66.8% | \$ 1,157,236 | 70,498 | | \$ 745,954 | \$ 411,282 |
| <i>Early Intervention</i> | 14,852 | 11,886 | 80.0% | \$ 13,693,170 | 468,221 | | \$ 8,826,617 | \$ 4,866,553 |
| <i>Health Check Coord</i> | 933,208 | 816,307 | 87.5% | \$ 2,871,750 | 8,274,961 | | \$ 1,851,130 | \$ 1,020,620 |
| Total | | | | \$ 139,346,886 | 15,317,672 | | \$ 91,047,443 | \$ 48,299,443 |
| Bundled Service Programs | | | | | | | | |
| <i>SubAbuseIntervOutpat</i> | 1,190 | 798 | 67.1% | \$ 2,591,956 | 17,999 | \$ 994,985 | \$ 641,367 | \$ 353,618 |
| <i>Assertive Comm Tx Tm</i> | 2,762 | 1,137 | 41.2% | \$ 30,422,785 | 94,074 | \$ 1,616,024 | \$ 1,041,689 | \$ 574,335 |
| <i>Comm Support Team</i> | 5,564 | 3,053 | 54.9% | \$ 100,282,481 | 5,862,194 | \$ 3,209,897 | \$ 2,069,099 | \$ 1,140,797 |
| <i>Intensive InHome Svcs</i> | 4,152 | 3,349 | 80.7% | \$ 46,226,294 | 179,522 | \$ 2,338,225 | \$ 1,507,220 | \$ 831,005 |
| <i>Multi-Systemic Therapy</i> | 508 | 406 | 79.9% | \$ 4,956,193 | 132,850 | \$ 312,113 | \$ 201,188 | \$ 110,925 |
| <i>SA CompOutpat Tx</i> | 504 | 370 | 73.4% | \$ 3,409,031 | 69,224 | \$ 1,530,543 | \$ 986,588 | \$ 543,955 |
| Total | | | | \$ 187,888,740 | 6,355,863 | \$ 10,001,786 | \$ 6,447,151 | \$ 3,554,635 |
| Community Support Programs | | | | | | | | |
| <i>CommSupp-Child</i> | 43,248 | 34,576 | 79.9% | \$ 294,624,481 | 21,151,258 | \$ 24,930,145 | \$ 16,069,971 | \$ 8,860,174 |
| <i>CommSupp-Adult</i> | 22,099 | 12,174 | 55.1% | \$ 121,578,635 | 8,725,657 | \$ 12,699,174 | \$ 8,185,888 | \$ 4,513,286 |
| <i>CommSupp-Gp</i> | 582 | 431 | 74.1% | \$ 246,244 | 56,368 | \$ 7,882 | \$ 5,081 | \$ 2,801 |
| Total | | | | \$ 416,449,360 | 29,933,283 | \$ 37,637,201 | \$ 24,260,940 | \$ 13,376,261 |

DRIVE data were queried October 12, 2009 for Dates of Service July 1, 2008 to June 30, 2009 (SFY 2009)
 Query criteria for each program/service are given in Table 2.
 CCNA counts were run on 07/21/2009 using criteria specified by CCNC

Providers

- ❑ CAP-MRDD – Private agencies endorsed by LME
- ❑ CAP-DA – case management provided by lead agency. Can be DSS, hospital, home health or senior program
- ❑ CAP-C – case management provided by local county agencies such as DSS, hospital, home health, or case management agency
- ❑ Case Management agencies providing case management to people with DD
- ❑ Local public health depts. and other agencies who provide other types of case management such as Maternal Care, Child Service Coordination, EI, etc.

- ❑ ICF-MR facilities are not effected because case management is part of the per diem. It is part of the social worker function and may not be billed separately.

General vs Specialized CM

- ❑ The definition of case management is the same across program types
 - As the program silos are eliminated and administrative functions reduced, staff qualifications can be “general”
 - Acuity of the recipient may require “specialized” CM or more highly trained
 - Qualifications will be based upon the required expertise of recipient acuity, not based upon disability, condition or provider type
 - Differentiate rate based upon the qualifications not on provider type
- ❑ Access will be based upon the clinical policy criteria

Short Term Plan

- ❑ Limit Number of Units and clarify the entrance, continued stay and discharge criteria
- ❑ Increase Administrative Efficiencies: Examples:
 - *Allow direct billing for CAP DME waiver supplies*
 - *Consolidate and reduce forms*
 - *Align CAP waiver policies*
- ❑ Modify rate structure
 - *Standardize rates among programs*
 - Move to a case rate structure instead of current method of billing in 15 minute units

Short Term Plan

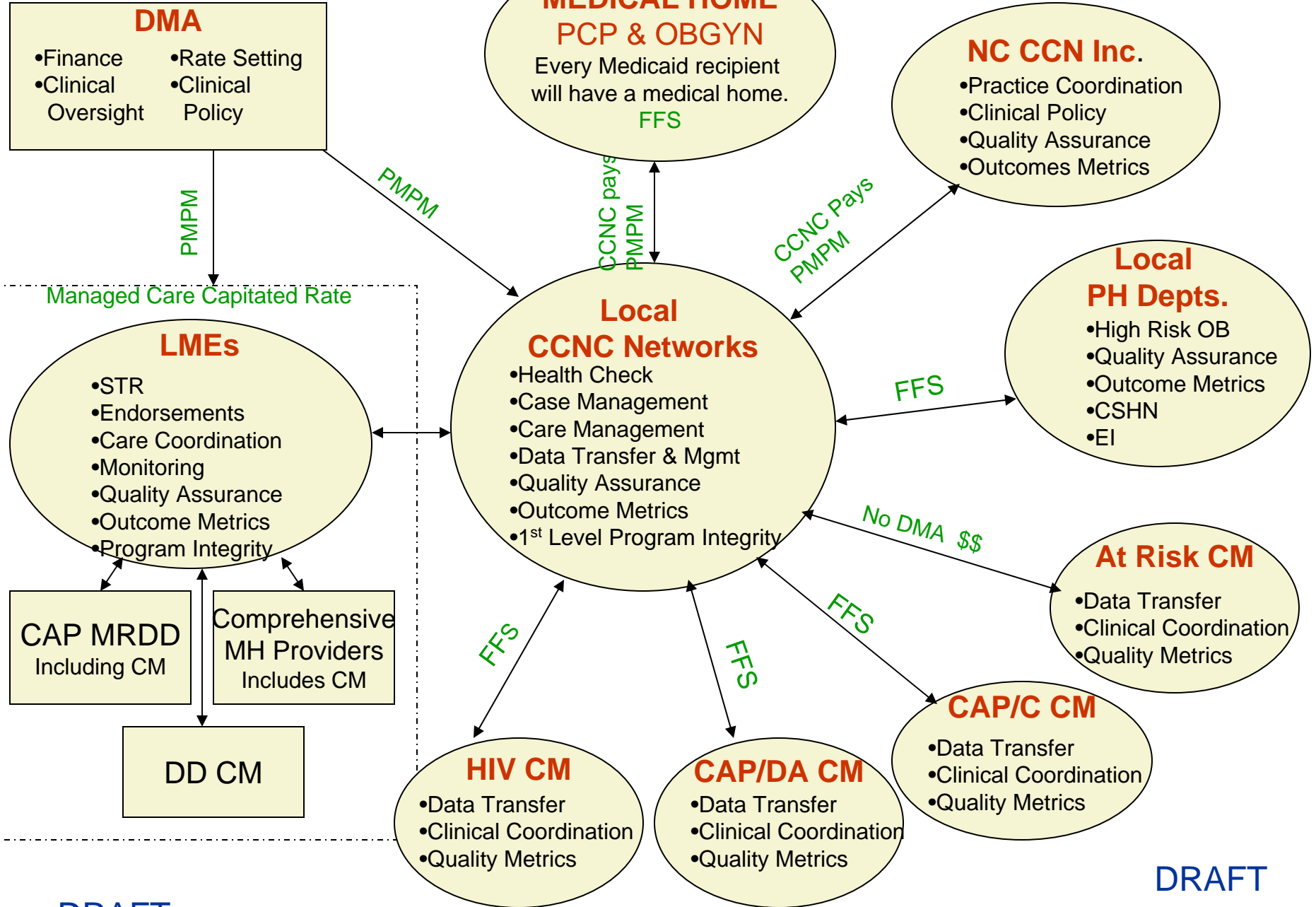
- ❑ Eliminate duplication
 - *Place audit in system to not allow billing by more than one CM provider in the same month*
 - *Examples: CAP-MR/DD with Community Support, HIV CM with Community Support, MST with Community Support, Maternal Care with Community Support*
- ❑ Develop linkages to CCNC networks and Primary Care Physician
- ❑ Reduce or eliminate prior authorization on targeted case management, when appropriate
- ❑ Coordinate with CS workgroup and make changes as needed
- ❑ ***Residual effect of consolidating case management will be a reduction of other health care/Medicaid services through better coordination***

Projected Savings

| Recommended Change | Projected State Savings 2010 |
|--|------------------------------|
| Establish Unit Limits or modifying criteria (effective 11/1/09) <i>finalizing limits</i> | \$10 -13,000,000 |
| Eliminate Duplication (effective 11/1/09) | \$ 2,500,000 |
| Eliminate Prior Approval on CAP-MRDD | \$ 1,400,000 |
| Consolidate Health Check into CCNC (effective 11/1/09) | \$ 280,000 |
| TOTAL | \$14 -17,180,000 |

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CASE MANAGEMENT SERVICES



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CCNC's Role

- ❑ Identify high risk factors with TCM agencies and ensure clinical coordination
- ❑ Develop patient risk profiles for entities such as LMEs who are charged with care management activities for an assigned population
- ❑ Expand key medical information to be provided for all Medicaid patients at point of care to prevent service duplication and optimize coordination of care
- ❑ Expand role of privacy officers and deploy network staff facilitate appropriate data transfer and clinical coordination with private case management agencies on a patient by patient basis
- ❑ Care Management functions to Health Check enrollees
- ❑ Per Member/Per Month will be increased for CCNC to provide for infrastructure enhancements

Future Plans

- ❑ Develop Service Definition
- ❑ Revise and submit State Plan Amendments (SPAs) to CMS
- ❑ Define outcome metrics for each area of CM
- ❑ Define risk factors that indicate CM (general and specific) needed for each area
- ❑ Submit CAP waiver revisions to make program policies more consistent

Future Plans cont'd

- ❑ Modify business processes and roles as a result of changes
- ❑ Develop data sharing processes and agreements
- ❑ Revise payment structure
- ❑ Determine implementation strategy and plan
- ❑ Develop Time Line for implementation
- ❑ Develop transition plan for current recipients and providers
- ❑ Develop Training plan

Coordination with Community Support Work Group

- ❑ Case Management definition is being submitted to CMS
- ❑ Comprehensive MH providers will be responsible for providing case management as a part of their services.
- ❑ DD Case Management will remain as stand alone agency and not be a comprehensive provider.