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Integrating Case Management Services in a Managed Care Environment

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Executive Summary

In recent years, several factors have converged to focus attention on the need to reform case management systems in Texas, particularly those for pregnant women and children operated by the Texas Department of Health's (TDH) Title V agency, the Bureau of Women and Children. This re-examination of the state's case management systems is being driven, in particular, by the following factors: a budget shortfall; the expansion of Medicaid managed care; an emphasis on preventive care under the state's Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and several statewide efforts to streamline case management.

In light of these important developments, TDH's Bureau of Women and Children requested technical assistance from Health Systems Research, Inc. (HSR) in identifying strategies for adapting Title V case management systems to the changing health care environment. HSR, a health policy research and consulting firm in Washington, D.C., is under contract with the federal Maternal and Child Health Bureau, Department of Health and Human Services to provide technical assistance by 1997 to all 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico in support of their efforts to develop comprehensive systems of care for children and their families. As requested by TDH officials, HSR's technical assistance report presents a range of alternative strategies to improve TDH's Title V case management systems for pregnant women and children. The information provided in this report is intended to inform decision making by Texas health officials regarding the future structure and operations of Title V case management programs under managed care.

A. Improving Standardization Across Title V Case Management Programs

After studying and assessing a range of existing case management programs for pregnant women and children in Texas, HSR developed guidance for consideration by Texas health officials for improving standardization across case management programs funded and administered in part by Title V. The proposal outlines three levels of case management comprising a graduated scale of case management interventions from least intensive (Level I) to most intensive (Level III). Specifically, the model posits that clients (and their families) present different degrees and combinations of risk factors, and also possess varying skills and capacities to access needed services. In combination, a family's level of need and functional capacity indicates what level of case management they should receive. For example, a family with a medically fragile child is likely to need more intensive case management than a family with a healthy child. However, if that family possesses the skills necessary to access needed services, it may not need the most intensive version of case management. The goal is to provide the most appropriate level of case management for each client.

A brief overview of the proposed levels of care is provided below and described in more detail in Chapter III:

- Level I. Level I case management may be appropriate for any client and involves the basic provision of outreach, information, and referral services. This type of care coordination helps assure access to needed services. Typically, families receiving Level I case management have the skills and ability to access services, but are not aware of all of the services that may be available to them.

- Level II. Level II case management is appropriate for individuals and families requiring assistance beyond the basic level of informing and outreach provided in Level I. Two groups in particular may require this more intensive level of case management:

  - Individuals at risk of poor growth and development due to psychosocial and environmental factors including, for example, poverty, teen pregnancy, living in a single parent household, and history of abuse or neglect; and

  - Families with children with serious and long-term conditions ("medically involved") of a duration in excess of one year that are generally high

functioning but who still need some assistance in planning and coordinating their receipt of multiple services.

- Level III. Level III case management is geared to the following two groups of individuals:

  - Families of children with medically complex or medically fragile conditions, including those who may be at risk for institutionalization; and

  - Families experiencing multiple or severe psychosocial and environmental risk factors that place the family at risk for disintegration.

  Typically, families in the above category do not have the skills necessary to manage their children's needs within the home and community environments, nor do they have sufficient knowledge, skills, or support to access the full range of health, social, developmental, and educational services that their situations require. Families receiving Level III care coordination require frequent intervention, education, and support.

B. Integrating Case Management with Managed Care Systems

As Texas is in the process of transitioning to a health care system that will be increasingly dominated by managed care, maternal and child health officials need to determine how best to implement Title V case management in a managed care environment. For this report, HSR identified a range of strategies for integrating the proposed levels of case management with both risk-based managed care (RBMC) and primary care case management (PCCM) models of managed care, both of which are included in Texas' evolving Medicaid managed care system.

Because TDH has begun to serve Medicaid-eligible persons through managed care arrangements (including SSI recipients on a voluntary basis), it is critical and timely for the agency to decide:

- Which types of case management activities should be included within the basic benefit package that managed care organizations are responsible for providing, either directly or through subcontractual arrangements with other community providers; and

- Which case management services should be carved out and, therefore, delivered and financed separately from those services included in the basic benefit package being provided under managed care.

Using the above framework, HSR provided guidance to TDH regarding how Levels I, II, and III case management services could be delivered and paid for under both RBMC and PCCM arrangements. In brief, it is suggested that TDH require Medicaid managed care providers, including both RBMC plans and PCCM providers, to deliver Level I case management within existing payment arrangements. For Level II case management, HSR suggests that RBMC providers be held responsible for the provision of this service either directly or through their networks of community providers and, furthermore, that they be paid a supplemental premium for providing the service. However, it is recommended that PCCM providers not be asked to perform this service, as doing so would exceed the typical capacity of such caregivers. For Level III case management, it is likely to be most appropriate for this service be carved out of the responsibility of both RBMC and PCCM providers—as this intervention demands skills and capabilities that typically exceed the capacity of managed care providers—and that it be provided by alternative Title V-funded providers in return for capitated payments. These suggestions are summarized in the table below.

Summary of Suggested Approaches for the Delivery and Financing of Case Management Services under RBMC and PCCM Arrangements.

Level of Case Management	RBMC Arrangements		PCCM Arrangements	
	Service Delivery	**Financing**	**Service Delivery**	**Financing**
Level I	RBMC responsible	Basic capitation rate	PCCM responsible	Basic case management fee
Level II	RBMC responsible, but contracting encouraged	Supplemental premium	Carved out	Capitated fixed fee
Level III	Carved out	Capitated fixed fee	Carved out	Capitated fixed fee

C. Refining Future Roles for TDH Staff

This report concludes with a discussion of how TDH, specifically its Title V program, might adapt to the significant changes taking place in the Texas health care system. In particular, the tension between continuing to provide and pay for services that managed care providers will have a large role in delivering vs. focusing on broader systems development activities, such as core public health functions, is explored. Because TDH can expect that providing and overseeing the delivery of case management services will be a priority regardless of which overall direction the agency pursues, this report identifies a range of activities for both central and regional office TDH staff in shaping the way case management services will be delivered in managed care settings. Finally, this report discusses several short-term objectives that TDH will need to address to implement the case management proposals included in this report. These include:

- Designing a risk assessment instrument and system;
- Developing referral protocols;
- Developing service delivery protocols for case management services; and
- Establishing provider qualifications and processes for certification. In conclusion, this report emphasizes the important potential role that case management can play in helping clients to understand and negotiate new service delivery systems and arrangements and applauds TDH for its leadership in ensuring that all clients receive a level of case management appropriate to their needs.

CHAPTER I

Introduction and Overview

Like many other health departments across the country, the Texas Department of Health (TDH) has a long tradition of providing health and social services to underserved populations. In particular, its Title V Maternal and Child Health program plays a major role in delivering preventive and primary care services to women, infants, children, and adolescents, as well as specialty services to children with special health care needs (CSHCN). Among the direct services provided through the Texas public health system is case management. Case management services are targeted to vulnerable populations, including high-risk pregnant women and infants and CSHCN.

In recent years, several factors have converged to focus attention on the need to reform case management systems in Texas, particularly Title V case management programs for women and children. This re-examination of the state's case management systems is being driven, in particular, by the fiscal, legal, and policy pressures described below:

- Budget shortfall. Like many other states, Texas is experiencing a budget shortfall that has reduced funding available for state-supported services. As costs for the state's maternal and child health programs have increased beyond available resources, TDH has recognized the need to re-evaluate program priorities, including the delivery of case management and other direct services, while also seeking ways of maximizing federal Medicaid funds.

- EPSDT lawsuit against TDH. On September 1, 1993, responsibility for the Texas Medicaid program's purchased health services operations was transferred from the Department of Human Services, the state's welfare agency, to TDH. On that day, TDH was sued for allegedly failing to provide the level of care required by federal law to Medicaid-eligible children enrolled in the state's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. After two years of negotiations, a consent decree was signed that contained 12 items

relating to case management. The plan for implementing the consent decree must be finalized by January 31, 1996.

- Expansion of Medicaid managed care. To improve access and the quality of health care services for low-income populations, as well as to enhance its share of federal Medicaid revenues, Texas is expanding its Medicaid managed care program statewide. On August 31, 1995, the state submitted a Section 1115 Research and Demonstration waiver application to the Health Care Financing Administration to expand Medicaid coverage of low-income persons,[1] including SSI recipients, and to require their enrollment in managed care arrangements. The waiver would be implemented over a five-year period. Given that TDH will be responsible for implementing portions of the waiver, the Department is exploring alternative service delivery and financing strategies for integrating case management with managed care systems.

- Statewide efforts to streamline case management. Two key interagency initiatives to improve standardization and coordination of case management activities are currently underway, both of which involve TDH as a central player:

  - The first is that spearheaded by the Health and Human Services Commission (HHSC), created by the Texas legislature in 1991 to coordinate efforts of the state's 11 health and human service agencies. In January 1994, the Senate Health and Human Services Committee directed the HHSC to consolidate case management activities across state agencies. The HHSC has recently surveyed all state agencies regarding their case management activities and is in the process of compiling and analyzing the findings for a report back to the legislature.

  - The second initiative, the Interagency Case Management Workgroup, was established in early 1995 to accomplish a similar goal. In particular, this committee is promoting the use of consistent case management provider training materials, specifically those developed by TDH's Bureau of Community Oriented Primary Care.

In light of these important developments, TDH requested technical assistance from Health Systems Research, Inc. (HSR) in identifying strategies for adapting its Title V case management systems to the changing health care environment. This report, produced through the support of

[1] Expanded coverage levels are as follows: children ages one to 18 up to 133 percent of the federal poverty level (FPL); and AFDC families, single individuals, and childless couples with incomes at or below 45 percent of the FPL (the state hopes to increase the income threshold for these latter groups from 45 to 75 percent of FPL).

the federal Maternal and Child Health Bureau (MCHB), is the outcome of this technical assistance effort.

A. Overview of HSR Technical Assistance

In the winter of 1995, the State of Texas was selected by the MCHB to receive technical assistance in support of its systems development efforts. Health Systems Research, Inc., a health policy research and consulting firm in Washington, D.C., has two contracts with the MCHB to provide such technical assistance to all 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico. The specific nature of the technical assistance is determined by officials of the individual states.

The Texas Department of Health's Associateship for Health Care Delivery, specifically its Bureau of Women and Children, originally asked for technical assistance in planning and implementing a strategic planning process to redefine the Title V program's role in the state's changing health care environment. On May 23-25, 1995, HSR Associate Director Ian Hill, Senior Associate John O'Brien, and Policy Associate Beth Zimmerman conducted an initial site visit to Texas during which they participated in a two-day summit meeting of the Future's Project, TDH's Title V strategic planning initiative. During this visit, the consultants also conducted follow-up meetings with numerous TDH officials to refine the focus of the technical assistance assignment. For the reasons identified above, TDH officials ultimately decided that HSR should concentrate its technical assistance resources on an examination of the state's Title V case management programs.

To support HSR in its technical assistance efforts, TDH created the Case Management Oversight Workgroup comprising individuals from its Associateships for Health Care Delivery and Health Care Financing. Specifically, members of this Workgroup include representatives of

the Bureaus of Women and Children, Community Oriented Primary Care, and Managed Care, as well as representatives of the state's umbrella Health and Human Services Commission.

On September 19-20, 1995, the HSR consulting team conducted a second two-day site visit to Austin hosted by the Case Management Oversight Workgroup to obtain background information on TDH's case management systems for women and children. This team included Ian Hill and Beth Zimmerman of HSR as well as Phyllis Siderits of the Florida Children's Medical Services program who—due to her extensive expertise in managed care, case management, and CSHCN issues—was secured as a consultant on this assignment. During this visit, the consultants gathered background information on TDH's case management programs, previous and current efforts to improve coordination among case management programs and agencies, and the state's managed care initiative.

Drawing on the information gathered from members of the Case Management Oversight Workgroup and other key officials and case management providers, the consultant team developed this report for the Texas Department of Health during the fall of 1995. This report constitutes the final product of HSR's consultancy with the State of Texas.

B. Purpose and Organization of this Report

As requested by the Case Management Oversight Workgroup, this report presents options and recommendations for strategies to improve case management systems for women and children administered and funded in part by Title V. In particular, this report includes recommendations regarding ways to improve standardization across TDH's case management programs and ensure that individuals being served through managed care arrangements receive a level of care appropriate to their needs.

The remainder of this report is organized as follows:

- Chapter II provides an overview and assessment of existing Title V systems of case management for women and children operated by the Texas Department of Health;

- Chapter III presents a detailed proposal for improving standardization across Title V case management programs and, specifically, presents a three-tiered model for case management services of varying intensity;

- Chapter IV discusses alternative and recommended strategies for integrating Title V case management with Medicaid managed care systems; and

- Chapter V discusses critical implementation issues likely to be confronted by TDH as it reforms case management systems for women and children, including considerations for future Title V roles in the changing health care environment.

CHAPTER II

Overview of TDH's Existing Case Management Systems for Pregnant Women and Children

The State of Texas administers a variety of case management programs for vulnerable populations. Case management programs are operated by eleven health and human service agencies including, for example, the Texas Department of Mental Health and Mental Retardation, the Interagency Council on Early Childhood Intervention Services, the Texas Commission for the Blind, the Texas Commission on Alcohol and Drug Abuse, and the Texas Department of Health. Although responsibility for providing case management services in Texas is shared among this broad array of agencies, in accordance with the focus of the HSR technical assistance assignment this chapter focuses specifically on programs for pregnant women and children currently operated by the Texas Department of Health, with a particular focus on those administered and funded in part by Title V. This information is based on interviews conducted by the technical assistance team during its September 1995 site visit to Austin.

A. The Structure of Title V Case Management Systems

The operation of TDH case management programs involves staff at the central and regional level as well as local agency contractors, as described below:

- At the central office level, Title V staff establish guidelines for case management services, develop training materials, and execute the process through which Title V contracts are awarded to case management providers.

- In TDH's eight regional offices, public health nurses and social workers play a major role in directly providing Title V case management services to children with special health care needs.

- At the local level, 60 of the state's 80 local health departments (LHDs) have contracts with Title V to provide direct services, including case management. In addition, the state's Title V/CSHCN program—the Chronically Ill and Disabled Children's Services program (CIDC)—funds the delivery of case management services through contracts with approximately 20 local agencies including hospitals, universities, and non-profit parent-run organizations.

As indicated by this multi-level staffing and contracting structure, case management has traditionally been a high priority of Title V and the state's maternal and child health community. Furthermore, strategic planners involved with the Title V Futures Project recommended that case management remain a high priority given the need for integrated service delivery under Medicaid managed care. Specifically, the Futures Project's CSHCN Services Committee identified case management, particularly an individualized and intensive version of case management, as a priority service for future Title V funding.

B. Overview of Title V-Related Case Management Activities

Existing TDH case management programs may be grouped into three categories, according to the target populations they serve: pregnant women and infants, children, and children with special health care needs. Case management programs for each of these populations are described below.

1. Case management for pregnant women and infants

In 1989, the state legislature required the Texas Department of Human Services (TDHS, then the single-state agency responsible for administering the Medicaid program[2]) to establish a case management program for high-risk pregnant women and infants up to age one. To comply with this mandate, TDHS added targeted case management to its state Medicaid plan as a covered service and contracted with TDH to implement the program.

[2] The umbrella Health and Human Services Commission is now the single state Medicaid agency.

To qualify for targeted "Pregnant Women and Infants" (PWI) case management, pregnant women and infants must be found through a risk assessment process to be at high risk for poor outcomes based on a variety of factors, including a history of medical complications, and inadequate nutritional status. Those who qualify receive a comprehensive and intensive version of case management. In particular, program rules outline six key case management activities including: initial intake; comprehensive needs assessment; development, implementation, and monitoring of a service plan (three distinct activities); and ongoing reassessment of client needs and progress. The overall purpose of targeted case management, as defined in program rules, is to "assist eligible individuals to access and utilize needed medical, nutritional, social, educational, developmental, and other appropriate health services."

Currently, there are approximately 90 providers of targeted PWI case management services for pregnant women and infants. Of these, about half are local health departments and 18 are local school districts. The eight TDH regional offices are also enrolled as targeted case management providers, as are a variety of hospitals and home health agencies. Nurses and social workers within all of these agencies deliver the case management services to clients. While Medicaid can only be billed for services provided to Medicaid-eligible clients, Title V funds support the delivery of the same level of case management to high-risk pregnant women and infants who are not covered by Medicaid.

2. Case management for children with special health care needs

Along with high-risk pregnant women and infants, children with special health care needs comprise Title V's second key target population for case management services. Primarily two existing programs currently provide case management services to this group.

- Chronically Ill and Disabled Children's Services. CIDC, the state's Title V CSHCN program for children meeting certain financial and medical eligibility requirements, includes an active case management component. Like the targeted case management program for pregnant women and infants described above, CIDC's case management program is geared toward providing intensive,

individualized assistance to CSHCN and their families, and facilitating access to needed services.[3]

As mentioned above, CIDC case management services are delivered by a broad range of providers, including TDH regional social work staff[4] and a variety of local agency contractors including universities, hospitals, and parent-run organizations. Not surprisingly, these entities often provide very different models of case management. Some employ professional nurses and social workers, while others utilize lay practitioners. Some tend to focus on medical issues, while others, such as parent-run organizations, are more likely to concentrate on delivering educational information and peer support. Case management caseloads also vary significantly across providers, as demonstrated by a recent survey of the state's Health and Human Services Commission which found that TDH's CIDC providers (including TDH regional staff and local contractors) manage average caseloads ranging from as few as 39 to as many as 1400, with 500 on average.

- Medically Dependent Children Program. The Medically Dependent Children Program, which operates under a Medicaid 1915(c) Home and Community-based Services waiver, allows a limited number of children[5] who are at risk for institutionalization and need skilled nursing care to remain and receive services at home. MDCP teams consist of caseworkers, nurses, contract managers, and Medicaid eligibility workers. Care planning is an integral component of MDCP services. TDH recently assumed responsibility for this ten year-old program from TDHS.

3. Case management for children

The Community Oriented Primary Care model promoted through TDH's Bureau of COPC espouses a model of primary care that recognizes families' need for coordinated and integrated services. TDH operates two managed care pilot projects that serve a large number of families with children and through which a basic level of case management is provided to all enrollees. As indicated earlier, the pilots include both health maintenance organization and primary care

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3 In addition to serving the target population of children in the CIDC program, these case management providers also serve special needs children who are not enrolled in CIDC.

4 In accordance with federal rules that require the CSHCN program to provide care coordination services to SSI child beneficiaries, regional staff provide outreach and case management services to SSI-eligible children as well.

5 As of September 25, 1995, 702 children were enrolled in MDCP and 496 were on a waiting list for the program.

case management models. These models, however, provide fundamentally different types of case management. Whereas case management provided through health maintenance organizations tends to focus primarily on managing utilization and cost of services during episodes of illness, that provided through primary care case management arrangements tends to be broader in scope, aiming to link clients with an appropriate range of services within and outside of the primary care provider's office. Further discussion of managed care and issues related to the delivery of case management services within managed care arrangements is provided in later chapters of this report.

C. Analysis of Title V-Related Case Management Programs

In meeting with members of the Case Management Oversight Workgroup and other key officials and case management providers, the consultants identified numerous important characteristics of existing case management programs for pregnant women and children. In particular, an important contrast was noted between a key strength—TDH's establishment of comprehensive guidelines for case management services delivered through the Department's Bureau of Community Oriented Primary Care—and a key challenge facing the agency—the reality of implementing these guidelines at the service delivery level. This issue is discussed in more detail below:

- Development of guidelines for case management. The Bureau of Community Oriented Primary Care has recently developed comprehensive, multidisciplinary, and individualized guidelines for case management services. The Bureau's *Case Management Operating Instructions* espouse an intensive model of case management services, including such activities as advocacy, mutual goal setting, monitoring, education, information and referral, and family empowerment. This operating guide applies to case management services provided through the CIDC and targeted case management programs, as the case management components of both of these programs have been consolidated into the Bureau of COPC.

- Challenges to implementing TDH's vision of comprehensive case management services. Despite the development of an operating guide for comprehensive case management services by the Bureau of COPC, TDH has not succeeded in implementing this model across its various Title V-related programs. For example, regional TDH staff have limited ability to serve large numbers of children and families in need. In addition, local case management

contractors report significant variations in case management procedures across different providers. These variations include differences in the level of training of case management providers; the time spent performing various components of case management (e.g., intake, assessment, and service planning); and in the prioritization of populations for receipt of services.

In addition, several other important observations about TDH's case management programs were made, including the following:

- Extensive collaboration among case management providers. Regional and local case management providers noted that referral arrangements between programs constitute an important strategy for conserving limited resources. For example, the Public Health Region XI representative indicated that they have a particularly strong referral arrangement with the Interagency Council on Early Childhood Intervention's local early intervention program, which provides targeted case management for developmentally-delayed children up to age three. This arrangement allows regional staff to focus on other populations in need of services.

- Strong involvement of parent and advocacy groups. Title V-funded and other local parent case management and advocacy groups were noted as playing a critical role in the existing case management system, particularly because of their family- and community-based perspective and sensitivity to the special concerns of families with CSHCN. In addition, these and other case management providers play an important role in linking families with a range of non-medical services including counseling, crisis care, and educational and developmental services. During the consultants' site visit many interviewees expressed their hope that parent and advocacy groups would continue to be supported as managed care expands statewide.

- Participation in broader interagency efforts to coordinate case management activities. As indicated earlier, TDH is a critical player in statewide efforts to improve standardization and coordination of case management activities, particularly those being spearheaded by the Health and Human Services Commission and the Interagency Case Management Workgroup described previously.

- Opportunity to maximize federal funds. To date, TDH has not maximized federal Medicaid revenues for case management activities. Even for the PWI targeted case management program, which is explicitly covered through Medicaid, billing has been limited by existing regulations and administrative requirements. TDH is now pursuing coverage of case management as an administrative activity for which Medicaid match could be obtained.

- Existing case management guidelines do not address all levels of need. While the COPC case management guidelines provide a model for an intensive version of case management, they may not be appropriate for women and children with lower levels of need.

- Limitations of current managed care arrangements. While both of TDH's managed care pilots include some version of case management, the existing managed care contracts contain little detail regarding how case management services are to be delivered. Furthermore, interviews with publicly-funded case management providers indicated that collaboration between these providers and private managed care organizations is generally limited.

Given the current challenges facing TDH in operating its case management services, Title V staff are interested in identifying strategies for improving standardization across its case management programs for women and children and integrating case management services into the state's emerging Medicaid managed care system. The following chapters include HSR's recommendations for assisting Title V in achieving these important goals.

CHAPTER III

Proposal for Enhancing Title V Case Management Systems in Texas

Case management, or care coordination, is widely considered by program officials and policy makers to be a critical component of the maternal and child health care delivery system. Often considered a panacea, case management is viewed as an intervention that: (1) improves access to services; (2) improves the quality of services; and (3) reduces the costs of care by efficiently coordinating the delivery of services. Since the late 1980s, case management has been a key element of most states' Medicaid-financed prenatal care systems. It has also become an integral component of states' efforts to create comprehensive, family-centered, and cost-effective systems of care for children, including children with special health care needs (CSHCN) and their families.

As discussed in previous chapters, the Texas Department of Health's (TDH) recent efforts to improve case management systems have responded to a variety of environmental factors. However, its case management activities for women and children are fundamentally guided by federal Title V and Medicaid law, as described below.

Title V of the Social Security Act articulates specific coordination and service provision roles for Title V Programs. As amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), these purposes include:

- The provision and assurance of access to quality maternal and child health services to mothers and children, particularly those with low income or limited availability of services;
- The provision of rehabilitative services for blind and disabled children under the age of 16 receiving Supplemental Security Income (SSI) benefits, to the extent that these services are not provided by the Medicaid program; and

- The provision and promotion of family-centered, community-based, coordinated care, including care coordination services for CSHCN and development of community-based systems of services for these children and their families.

Furthermore, Medicaid regulations address Title V coordination arrangements. In 42 C.F.R. § 431.615(d), Medicaid programs are required to specify in arrangements with Title V grantees methods for early identification of individuals under 21 in need of medical or remedial services. The Health Care Financing Administration's State Medicaid Manual of 1990 further outlines the assistance Title V programs can provide for the EPSDT program, including outreach, referral, and care coordination activities.

Building on the statutorily-defined role for Title V to provide care coordination services, HSR's work in improving case management systems for maternal and child populations in other states, and the experiences of other state agencies dealing with the developmentally disabled population, HSR has developed guidance for consideration by TDH officials in their quest to enhance Title V-funded case management services. This chapter first provides an overview of the conceptual framework underpinning HSR's guidance, and then presents a proposed model of case management services of varying intensity levels.

A. The Conceptual Framework

A variety of case management models have emerged as states have experimented with strategies for coordinating services for pregnant women, disabled individuals, and infants and children at risk of poor growth and development. One model used by several states involves the assignment of individuals in need of case management services into one of several levels of care, depending on the intensity of their needs and their family's knowledge, skills, or supports. This "level-of-care" model responds to the likelihood that one uniform set of case management services will not apply to all individuals. For example, TDH's COPC case management guidelines espouse an intensive version of case management that is appropriate for persons with significant needs but likely exceeds the requirements of individuals with lower levels of need.

In employing a level-of-care model, states need to identify at least three criteria for each available level of care, including:

- The type of individual who should receive that level of case management, based on the presence of certain risk factors;
- The case management functions appropriate for the specific level of care; and
- The appropriate caseload size for each level of care.

From systems and organizational perspectives, this particular model permits an agency to better identify needs for case management staff and, subsequently, create a more rational system of service coordination. From a customer perspective, the model recognizes families' strengths, concerns, and resources and focuses appropriate levels of attention on families based on their needs.

Certain basic assumptions are inherent in a level-of-care model for case management. Specifically, the model proposed here for Title V assumes that:

- Case management consists of a range of activities, including outreach, informing, education, screening, referral, service assessment and planning, family support and advocacy, service coordination, service and system monitoring;
- Individuals have differing needs, strengths, knowledge of services, ability to access services, and social supports;
- Certain case management functions—particularly outreach, informing, and education about how to access and utilize services—may be appropriate for any individual;
- Families may move among levels of case management based on changes in their external and internal environments; and
- Risk assessment is a critical first step in determining the need for a particular level of case management.

Building on these assumptions and HSR's experience working in other states, HSR has developed a set of recommendations regarding the implementation of a level-of-care model for consideration by TDH's Title V program. This proposal is presented in the following section.

B. A Case Management Proposal for Title V

The HSR consulting team has developed a proposal to assist Title V in achieving its goal of providing appropriate case management services to its many clients. This proposal is intended to expand upon and enhance the existing case management operating instructions developed by the Bureau of Community Oriented Primary Care in TDH's Associateship for Health Care Delivery.

Consistent with the conceptual framework discussed above, this proposal outlines three levels of case management comprising a graduated scale of case management interventions from least intensive (Level I) to most intensive (Level III). Specifically, the model posits that clients (and their families) will present different degrees and combinations of risk factors, and also possess varying skills and capacities to access needed services. In combination, a family's level of need and functional capacity will dictate what level of case management should be received. For example, a family with a medically fragile child is likely to need more intensive case management than a family with a healthy child. However, if that family possesses the skills necessary to access needed services, it may not need the most intensive version of case management. The goal is to provide the most appropriate level of case management for each client.

A brief overview of the proposed levels of care is provided below and described in more detail later in this section:

- Level I. Level I case management may be appropriate for any client and involves the basic provision of outreach, information, and referral services. This type of care coordination helps assure access to needed services. Typically, families receiving Level I case management have the skills and ability to access services, but are not aware of all of the services that may be available to them.

- Level II. Level II case management is appropriate for individuals and families requiring assistance beyond the basic level of informing and outreach provided in Level I. Two groups in particular may require this more intensive level of case management:

- Individuals at risk of poor growth and development due to psychosocial and environmental factors including, for example, poverty, teen pregnancy, living in a single parent household, and history of abuse or neglect; and

- Families with children with serious and long-term conditions ("medically involved") of a duration in excess of one year that are generally high functioning but who still need some assistance in planning and coordinating their receipt of multiple services.

- Level III. Level III case management is geared to the following two groups of individuals:

  - Families of children with medically complex or medically fragile conditions, including those who may be at risk for institutionalization; and

  - Families experiencing multiple or severe psychosocial and environmental risk factors that place the family at risk for disintegration.

  Typically, families in the above category do not have the skills necessary to manage their children's needs within the home and community environments, nor do they have sufficient knowledge, skills, or support to access the full range of health, social, developmental, and educational services that their situations require. Families receiving Level III care coordination require frequent intervention, education, and support.

Detailed descriptions of each of these proposed levels of case management follow. Specifically, for each level of case management, recommendations are provided regarding:

- The type of clients eligible for the specific level of case management;

- Appropriate functions of case managers providing that level of care;

- The duration and frequency of contacts; and
- Provider qualifications.[6]

1. Level I Case Management

Eligible clients. All clients could benefit from this basic level of care coordination. Families appropriate for Level I case management should generally have the knowledge, skills, and ability to access services but may need additional information about the availability of services.

Case management functions. The following types of activities could be included in the definition of Level I case management:

- Providing information about services to the general public and targeted groups;
- Conducting outreach to homes, schools, public service centers, and other appropriate organizations and agencies in order to identify individuals in need of services;
- Conducting risk assessments to determine the need for more intensive care coordination;
- Providing individually-based information and education about available services including how to access the services and appropriately utilize a service system;
- Screening for eligibility for certain programs;
- Providing referrals to services; and

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[6] The recommendations regarding provider qualifications build off of the existing case management standards developed by TDH's Bureau of Community Oriented Primary Care. However, the model expands upon these standards by incorporating opportunities for Title V to employ paraprofessionals as case management providers for individuals and families with less intensive levels of need. By employing these less expensive providers, Title V could be in a better position to extend limited resources over a broader population of clients and, in turn, come closer to reaching its goal of providing all families with appropriate case management services. While relaxing professional training standards for clients with less intensive levels of need, the model also specifies more rigorous professional qualifications for the higher-need clients who, due to their multiple and complex medical and/or social needs, demand a very intensive level of case management intervention. Implicit in this discussion is the understanding that case managers may be directly employed by Title V or by Title V grantees or contractors including local health departments and local organizations. It is recommended, however, that all selected case managers be required to complete a case management training program developed by Title V.

- Providing a name, phone number, and address of an individual to contact in case of problems or the need for additional case management.

Duration and frequency of case management. Generally, the duration of Level I case management will be less than one month. Outreach, information, and referral assistance can typically be conducted in one or two contacts with the family.

Provider qualifications. Level I case managers could include:

- Licensed registered nurses in the State of Texas;
- Licensed practical nurses or vocational nurses in the State of Texas;
- Social workers certified in the State of Texas; and
- "Community workers" with a high school education or an equivalent degree, including parents or family organizations; community workers should be supervised by a licensed registered nurse or social worker.

2. Level II Case Management

Eligible clients. Level II case management is targeted to: (1) individuals at risk of poor physical, intellectual, or emotional development due to psychosocial and environmental factors; and (2) families of children with chronic medical conditions who need assistance with planning and coordinating services associated with their child's special health needs, but who are generally fairly skilled in accessing needed services.

The first group of clients—"at risk" individuals—may include, for example, children born to a mother who is a teenager or who has less than a high school education, children who have experienced abuse or neglect, and pregnant women who are homeless or who live in overcrowded or inadequate housing (e.g., without plumbing). Persons at risk due to psychosocial and environmental factors and who have limited knowledge and skills to access and utilize services can benefit from a range of preventive interventions including case management, home visiting, and educational and skills-building counseling.

In addition, families of children with chronic health conditions may also benefit from this level of case management intervention. Families who fall into this category—those whose children have asthma or diabetes, for example—may not necessarily require a complex mix of services from a wide variety of agencies like those needing the more intensive Level III case management. Furthermore, they generally possess the skills, abilities, and support to access and utilize the service system. Assistance, however, is beneficial in helping these families to become aware of the array of services available in the community and in linking them with these services. Families are also likely to benefit from Level II case managers' role in monitoring that services are accessed and utilized appropriately.

Case management functions. The following functions could be included in the scope of work for Level II case managers:

- Conducting an initial assessment of health, environmental, financial, educational, and developmental needs of the child and family, ideally in the child's home;
- Developing a child and family care plan, in concert with the family, based upon family needs, strengths, and resources;
- Providing information and education about services to help families access and appropriately utilize services;
- Conducting an initial visit and periodic follow-up visits no less than once every three months for the purposes of assessing family needs and providing health education, support, and instruction on how to access services and manage the child's care;
- Arranging for enabling services such as transportation or interpreter services to promote access to health care services;
- Arranging for appropriate family support services including parent and caregiver training, health education, and nutritional and psychosocial counseling;
- Preparing and maintaining a case record, including service plans, forms, reports, and narrative progress notes;
- Assisting with referrals made by a client's primary care provider for specialty medical care services;
- Assuring the transfer of information between and among providers;

- Assisting with eligibility screening for specified programs;
- Providing resource directories and information about community resources that the family may need;
- Re-evaluating the need for continued or additional health services;
- Monitoring the family's ability to access and utilize services; and
- Providing other services that may be relevant to promoting family independence.

Duration and frequency of case management. Level II case management services are likely to extend from one to six months based on the needs of the client and family, with a re-evaluation at the end of six months to determine the need for additional services. It is recommended that TDH consider requiring that several contacts be made with the client and family, with some of these contacts occurring in the form of a home visit.

Provider qualifications. Level II case managers could include:

- Licensed registered nurses in the State of Texas with at least one year of community health nursing or pediatric nursing experience;
- Social workers certified in the State of Texas with at least one year experience in health and/or human services; and
- Professional/paraprofessional teams comprised of a professional in one of the above classes and a paraprofessional with a high school education or G.E.D.

3. Level III Case Management

Eligible clients. Level III, the most intensive version of the case management, is geared to the following two groups of clients:

- The first group includes children with complex chronic conditions who require multiple services from a wide variety of agencies and whose families have limited knowledge, skills, and supports to facilitate their successful utilization of needed services. This target population includes persons who may be at-risk for institutionalization.

- The second group of eligible clients include families experiencing several psychosocial and environmental risk factors that place them at risk for poor health and developmental outcomes and who, like the above group, have few coping and support skills to facilitate their successful utilization of needed care. Included in this group, for example, would be children who have been abused and whose families have multiple social risks likely to lead to a disintegration of the family unit.

Case management functions. Level III case management activities could include those outlined for Level II case management as well as the following functions:

- Conducting home visits at least monthly to assess the level of family intervention that is needed and to provide ongoing, intensive health education and psychosocial support;
- Assisting in the development of alternatives to hospitalization, when medically appropriate, to promote cost-effective care;
- Determining when a family is ready to case manage their child's care and needs;
- Working with other agencies to provide necessary in-home supports for the child and family and to reduce stressors that impact the preservation of the family unit;
- Arranging for transitional services (i.e., from pre-school to school, from adolescence to adulthood);
- Working with the family to improve its capacity to case manage the child's needs and to advocate for services; and
- Arranging for a variety of services that provide emotional support and enhance the family's caregiving and coping capacities.

Duration and frequency of case management. Level III case management may extend from six months to greater than a year based on continuous evaluations of child and family needs. Clients may benefit from frequent contacts with the case manager in the initial months of care coordination and follow-up contacts in accordance with the findings of a family needs assessment.

Provider qualifications. It is recommended that Level III case managers include the following professional classes:

- Licensed registered nurses in the State of Texas with at least a baccalaureate degree in nursing and three years of experience in community health or pediatric nursing. Title V may consider allowing a master's degree in nursing to substitute for one year of experience.

- Social workers certified in the State of Texas with at least a baccalaureate degree from an accredited school of social work and three years of experience in health/human services. Title V may again consider allowing a master's degree in social work to substitute for one year of experience.

TDH may also decide to employ parents as consultants to Level III case managers as part of a Level III team providing family support and advocacy. If a child is eligible for Level III care due to a complex medical condition, it is recommended that nurses serve as Level III case managers.

CHAPTER IV

Integrating Title V Case Management with Medicaid Managed Care

The proliferation of managed care nationwide presents important challenges to public health systems that have traditionally served maternal and child populations. In Texas, the expansion of Medicaid managed care has raised particular issues with regard to how the state's Title V-funded case management services will be provided in a health care system increasingly dominated by managed care.

As the Title V grantee, TDH's Bureau of Women and Children is mandated to develop effective systems of care for all mothers and children. This chapter is designed to support the Texas Title V agency in this role by exploring alternative models for providing case management services in a Medicaid managed care environment. As Texas plans to embrace both risk-based managed care (RBMC) and primary care case management (PCCM) models of managed care, this chapter will present options for incorporating case management into both of these types of arrangements.

Texas, like all other states, has yet to identify proven strategies for effectively integrating managed care and public health systems, including case management systems. The development of this report for Texas has provided HSR with an opportunity to explore alternative models for accomplishing this important goal.

Before discussing alternative strategies for integrating public health-based case management services and Medicaid managed care, however, it is critical to point out that the public health and private managed care sectors have traditionally embraced very different philosophies toward case management. Furthermore, the manner in which these two perspectives are merged will significantly shape how Title V case management services will be integrated with the state's

emerging Medicaid managed care system. The proposal presented in this report reflects a public health-oriented philosophy of case management; that is, the goal of the proposed case management system is to facilitate clients' access to a broad range of needed services, including not only medical care but appropriate social, family support, and other services. Furthermore, in keeping with this philosophy, the proposal includes various intensity levels of case management for clients with differing levels of need and abilities to access services.

This approach to case management differs significantly from that traditionally embraced by proprietary managed care organizations. Rather than using case management to facilitate access per se, managed care organizations typically use case management as a tool for managing episodes of illness and utilization of services. Historically, proprietary managed care uses case management as a cost containment devise for controlling expenditures. Another important difference between these two models lies in the criteria upon which case management decisions are driven. In the proposed public health model, decisions about the appropriate level of case management are based on clients' health and social risk factors balanced with their level of skill in accessing needed services, whereas case management decisions in proprietary managed care settings are typically driven by financial concerns.

To create a Medicaid managed care system that provides comprehensive and individualized case management services to Medicaid-eligible clients, Texas health officials will need to acknowledge both of these perspectives and work to find common ground between them. Doing so will help to ensure that goals for both high-quality and cost-efficient case management will be achieved within the state's evolving system of care.

A. Framework for Analysis: Alternative Service Delivery and Payment Arrangements for Vulnerable Populations under Managed Care

States have a variety of options when considering how to serve vulnerable populations under Medicaid managed care. These options range from exempting high-risk or high-cost groups from enrollment in managed care, to requiring managed care contractors to assume responsibility for serving all populations in a given area. While this chapter identifies options

for integrating a single service—case management—with managed systems of care, it is helpful to first place the issue within a broader contextual and analytical framework, one which outlines states' options for delivering and paying for services for vulnerable populations in a reformed health care system.

A comprehensive health care system must meet many diverse challenges. In addition to providing the full range of preventive, primary, and acute care services to the general population, it must provide chronically ill and disabled persons with access to the specialty care, technologies, and supplies needed to treat their conditions; assure that persons with serious emotional disturbances have access to a range of integrated, family-centered mental health services; and recognize that children who are at risk of poor growth and development due to social and environmental factors need early intervention as well as a host of nonmedical and psychosocial support services. Meeting these needs within a managed care environment presents an even more complex challenge, as the incentives inherent in capitated systems may encourage providers to avoid enrolling and/or limit services to high-risk or high-cost populations. In addition, many proprietary managed care systems have traditionally served predominantly healthy, middle-class clients and may be inexperienced in addressing the special needs presented by low-income and at-risk populations.

In serving vulnerable populations in reformed health care systems, several service delivery and payment options are available to states. Based on HSR's experience working in other states, three such options have been identified. These options, which apply not only to specific services but also to broader decisions about the structure of managed care systems, are described below:

- Carve out Selected Populations to Be Served Through a Separate System. Under this option, selected groups of clients may be exempt, permanently or temporarily, from enrollment in managed care. This option is often used by states implementing Medicaid waivers to exempt children eligible for SSI from statewide managed care initiatives. Although this option may serve to protect some high-risk individuals from the risks presented by managed care while protecting plans from the financial risks associated with their enrollment, it does not assure that all vulnerable persons are included in the carved-out population. It also denies these clients the potential benefits of coordinated services offered

through managed care arrangements. Under this option, services for carved-out populations may be paid for on either a fee-for-service or capitated basis.

- Carve out Selected Services to Be Delivered Through a Separate System. Rather than exempting an entire population from managed care, a state may choose to enroll all persons in managed care systems but carve out certain of the special services vulnerable groups may require and provide them through a separate system. Although this option may protect managed care plans from responsibility for the highest-cost services, it may also create a fragmented system of care in which certain individuals have two medical homes whose services may not necessarily be coordinated. This option also presents challenges with regard to determining which services should be carved out and clarifying the roles and responsibilities of each provider. Carved-out services may be reimbursed through capitation or fee-for-service payments.

- Make Managed Care Providers Responsible for Assuring All Services. Finally, states may enroll all persons in managed care arrangements and require that managed care providers assure that clients receive all the services they need. As a purchaser of services for a large number of clients, the state has considerable leverage over managed care plans, and could make its contracts with plans contingent upon the provision of certain services.

  It is important to point out, however, that this policy strategy raises fundamentally different issues for states depending on whether they are implementing risk-based managed care systems (that rely on HMOs, for example) or primary care case management models. Under RBMC, plans would receive a monthly per capita payment on behalf of each enrollee and, in return, would be required to assure that all enrollees' service needs will be met. Plans may be given varying levels of flexibility in meeting this obligation:

  - Plans may be given complete flexibility to provide services internally or contract with community providers for services;

  - Plans may be encouraged to include community providers with experience providing specialty, psychosocial or support services in their networks, perhaps by giving preference in the RFP process to plans that include these providers;

  - Plans could be required to include providers with specific qualifications in their networks as a condition of their contracts with the state; or

  - Plans may be required both to include community providers in their networks and to refer certain types of clients to these providers for specific services.

Under PCCM models of managed care, individual primary care providers are contracted to provide primary care services and manage referrals for all other needed care. Services are typically reimbursed on a fee-for-service basis and primary care providers also receive a nominal monthly case management fee for agreeing to serve a medical home for all of his/her enrollees. PCCM providers are not "at risk" for the services they refer for and thus do not face the same financial incentives as RBMC providers to underserve their clients. Also, since most PCCM providers practice either independently or in small groups, they will be less likely to be able to provide the full range of services that vulnerable groups often require. Therefore, this policy strategy applied to a PCCM model would entail the PCCM provider agreeing to assure that his/her enrollees will receive or be referred out for all needed care in return for the monthly management fee.

In developing Medicaid managed systems of care for vulnerable populations such as children with special health care needs, states have generally viewed PCCM models as less risky than RBMC models, for obvious reasons. Under a PCCM approach, vulnerable groups can enjoy the benefits of a primary care medical home while health care providers are not at financial risk for meeting these populations' needs within a fixed budget. However, by using a PCCM model for these groups, states may not fully realize the cost containment and service integration advantages that they would under a RBMC model, since services would still be paid for on a fee-for-service basis and service delivery would likely be more fragmented.

B. Applying the Framework to Texas' Systems

On 31 August 1995 Texas submitted a Section 1115 waiver application to HCFA that would require Medicaid recipients to enroll in managed care arrangements and would use the expected savings from this change to expand Medicaid coverage of low-income persons. Building off the state's experiences operating its two managed care pilots (described in Chapter II), the waiver would allow for the development of two types of managed care arrangements across the state: RBMC and PCCM models. While waiting to learn the status of its waiver application, the state is proceeding with its plans for managed care expansion by replicating its pilot projects in additional areas of the state.

Furthermore, TDH has determined that, rather than carving out certain populations from Medicaid managed care, it will serve persons with special health care needs through such arrangements. Specifically, the state plans to phase in coverage of SSI recipients who

voluntarily enroll under managed care as early as 1996 in some communities. However, Texas has not yet defined which services will be required to be provided by managed care providers as part of the basic benefit package. Therefore, the second and third options described in Section A above offer viable strategies for Texas in providing and paying for case management services under managed care. Specifically, the agency will need to decide:

- Which types of case management activities should be included within the basic benefit package that managed care organizations are responsible for providing, either directly or through subcontractual arrangements with other community providers; and

- Which case management services should be carved out and, therefore, delivered and financed separately from those services included in the basic benefit package being provided under managed care.

In the following section, alternative models for integrating Title V case management services with Medicaid managed care are presented. Given that Texas will be implementing both RBMC and PCCM managed care models, strategies for implementing different levels of case management are presented for both types of arrangements.

C. Providing Case Management Under Risk-Based Managed Care Arrangements

Under risk-based managed care arrangements, contracted providers agree to deliver a bundle of services for a fixed, per-person fee (the capitation rate) over a specified period of time. That is, the provider, or managed care organization, is "at risk" for the costs of providing the defined set of services to its enrollees.

There are both pros and cons to the financial incentives inherent in capitated, risk-based arrangements. On the plus side, providers who are paid a fixed monthly fee are motivated to deliver services in the most efficient manner possible. In addition, because they are at risk for the costs of providing all needed services, they should employ a prevention-oriented model of care to avoid high-cost episodes. On the negative side, however, providers who are at risk for all costs also have an incentive to limit enrollment of high-risk/high-cost clients or, once

enrolled, to limit their access to services. The implications of these incentives are particularly important when considering how to provide case management under RBMC arrangements. As noted earlier in this chapter, case management can be used either to control or enhance access to services, depending on whether the traditional proprietary managed care or public health perspective is dominant. If RBMC providers are trying to limit high service utilization rates and associated costs, they may face the incentive to avoid providing a version of case management that links clients with services they otherwise would not utilize.

The following discussion presents alternatives for providing case management services under RBMC arrangements. In accordance with the proposal presented in Chapter III, the discussion addresses, in turn, each of the three proposed levels of case management, starting with the least intensive version (Level I) and ending with the most intensive form of case management (Level III). In particular, each of these sections includes:

- A review of the level of case management being discussed, as well as of the type of client for which that level of care is appropriate;
- A discussion of the alternatives available to Texas officials regarding how to provide that level of case management under RBMC arrangements;
- A suggested approach for TDH; and
- A scenario illustrating how the recommended approach could work for a hypothetical client or family, or within a particular provider setting.

1. Level I Case Management

As described in Chapter III, Level I case management involves the basic provision of outreach, informing, and referral services. This type of care coordination, which forms a basis for assuring access to needed services, is helpful to families that have the skills and abilities to access services but are not aware of all of the services that may be available to them.

Based on the analytic framework presented in Part A above, TDH has two options for how to deliver and pay for Level I case management services under RBMC arrangements:

- The first option is for the state to carve out Level I case management from the basic service requirements of managed care providers, thereby establishing a

separate system for delivery and payment of Level I case management services; and

- The second option is to make plans responsible for assuring that this level of case management is provided to all enrollees, either by providing this service internally or contracting with community agencies for this purpose.

From both the provider and client perspectives, making managed care plans responsible for Level I case management has the advantage of linking these basic enrollee outreach and education services directly to the medical home, particularly if plans conduct these activities in-house. In addition, by helping to educate enrollees about the importance of preventive care and how to access these services through the managed care system, plans will promote an efficient and integrated model of care. On the other hand, managed care organizations to date have had limited experience in providing new enrollee outreach and education to vulnerable populations. This point may argue for having more experienced community groups provide this service, either by carving the service out or by encouraging plans to contract with community providers. In doing so, however, the state may inhibit plans from developing fundamentally integrated systems and may inadvertently discourage managed care plans from developing their expertise in managing the care of essentially healthy, but resource-limited, families.

- Suggested Approach. The type of activities covered by Level I case management, such as educating clients about the benefits available to them under the plan and how to use the managed care system, and encouraging the use of preventive screening and clinical services, are likely to benefit all managed care enrollees. Because such basic health education and information should be an integral part of plan administration, it is recommended that plans be required plans to assure that this service is available to its enrollees and, furthermore, encourage plans to develop the capacity to provide this service internally. Similarly, since the service should be considered fundamental to the basic benefit package, it should be reimbursed as part of the standard capitation premium paid on behalf of all members. A scenario illustrating how this approach could be implemented is presented in Case Example #1 below.

Case Example #1:
Level I Case Management Under RBMC Arrangements.

Ms. Lopez is a single mother living in Austin who works as a check-out clerk at a local supermarket. She and her two children have been Medicaid recipients for the past year, during which time they have received medical care from the local health department clinic. Recently, on a visit to the local social services offices to renew her eligibility status, Ms. Lopez was given the option of signing up with a managed care provider. Although she was generally satisfied with the level of care she and her children received at the clinic, she enrolled herself and her children with one of the optional HMO plans since it was closer to her home.

Two weeks after enrolling, Ms. Lopez received a letter in the mail from her new provider. This letter—which was written in both English and Spanish—invited Ms. Lopez to an orientation session to learn, along with other parents who had recently enrolled, about the plan's services. Three sessions were offered on different times and days, including one on the weekend. The letter noted that child care would be available during the orientation sessions, and a telephone number was provided to arrange transportation assistance if needed.

Having never been enrolled in an HMO before, Ms. Lopez decided to attend one of the morning sessions offered on a day she did not have to work and when her older child would be in school. On the allotted day, she walked with her younger son to the plan's clinic several blocks from her house. When she arrived, she was brought to a classroom, where several people were already gathered, and her son was shown to a supervised playroom where he could stay while she attended the orientation session. The group was then joined by two plan representatives who indicated that each would be leading a session, one in English and one in Spanish. Ms. Lopez joined the Spanish-speaking group.

During the one-hour session, Ms. Lopez and the other parents learned a variety of things about the services available through the plan and how to access the plan's services. For example, participants learned:

- What telephone number to call to make a routine appointment;
- That interpreter, transportation, and supervised child care services were available to patients during parent or sibling medical appointments;
- The importance of always going to their chosen or assigned primary care physician as a first step for all needed services;
- How to receive a referral from her primary care physician for specialty services;
- How to change primary care providers;
- The number for an "advice line" staffed 24-hours a day by nurses who can answer medical questions;
- Guidelines on when to go to the emergency room; and
- How to file a grievance if she is unsatisfied with a decision related to her care.

In addition, each participant received a packet of written information on the topics discussed during the orientation, as well as educational brochures about well-child exam and immunization schedules. At the end of the session, Ms. Lopez met with a plan representative to select a primary care physician, schedule well-child exams for her children and a physical for herself, and arranged for a van to pick her and her children up for their scheduled appointments.

2. Level II Case Management

As described in Chapter III, Level II case management involves the provision of information and referral services to families as well as family assessment, care plan development, home visits, support services, and assistance with the arrangement of services. Two groups in particular may require this more intensive level of case management:

- Individuals at risk of poor growth and development due to psychosocial and environmental factors including, for example, poverty, teen pregnancy, living in a single parent household, and history of abuse or neglect; and
- Families with children with serious and long-term conditions ("medically involved") of a duration in excess of one year that are generally high functioning but who still need some assistance in planning and coordinating their receipt of multiple services.

Based on the analytic framework presented above, TDH has two options of how to handle the delivery and payment of Level II case management services under RBMC arrangements:

- The state could elect to carve out Level II case management services from the basic benefit package for which managed care plans are responsible and establish a separate system for the delivery of and payment for this service. Under this option, the state could choose to have Level II case management services provided by individuals or agencies such as regional TDH staff or by contracted agencies. The state would need to specify risk-assessment and referral criteria in its managed care contracts to trigger a referral from the plan to an appropriate Level II case management provider. The Medicaid agency could purchase Level II case management services on a fee-for-service or capitation basis.

- Alternatively, RBMC plans could be made responsible for assuring that Level II case management is provided to eligible individuals based on the findings of a risk assessment. The case management could be provided directly by RBMC staff or by other entities such as a community agency or public health unit that is under contract with the plan. The state would need to include in its contracts with plans language that specifies case management functions and provider qualifications for Level II case management. Under this arrangement, Level II case management services could be paid for either through the plan's capitation rate or through a supplemental premium. If these case management services were included in the capitation rate, this rate would need to be adjusted to account for the increased cost of providing this service based on the activities that have been specified for Level II case management. There should also be some adjustment for the anticipated duration of Level II case management. Alternatively, the state could elect to pay for Level II case management through

a supplemental premium to the managed care plan in lieu of an all-inclusive capitation rate. This financing mechanism specifically targets individuals who require Level II case management and provides a direct incentive to managed care plans to appropriately provide Level II case management activities through salaried staff or contracted providers.

There are many pros, as well as cons, associated with each of these options. The benefit of requiring plans to be responsible for providing Level II case management is that continuity of care between and among the plan's network of providers is promoted. This arrangement is also feasible due to the fact that this level of case management will not occur on an on-going basis. Furthermore, salaried plan case managers report to and are accountable to the same organization that is providing the care, thereby decreasing the potential for conflicts between the plan and case managers. The benefit of a RBMC plan contracting with a community agency is that the plan may be able to select an agency that has more experience than itself in serving individuals who require Level II case management services.

The downside to this approach is that it requires plans to make an up-front financial commitment to building its case management staff capacity for a potentially small percentage of its covered members. Additionally, managed care plans' traditional commitment is to assure appropriate access to covered benefits that are traditionally medical or medically-related services; the plans may not have the same level of commitment to and skill in linking clients with social, educational, and other services that are not covered in its benefit plan.

The benefit of carving out Level II case management services from the managed care plan is that certain community agencies or other organizations may possess a much more sophisticated capacity to provide the service in a manner that is consistent with missions and objectives of Title V. On the other hand, carving out case management services has the potential to fragment the continuum of care; health care case management may occur within the plan while more socially-oriented case management services might occur through outside agencies. In essence, the individual may have more than one case manager.

- Suggested Approach. It is recommended that TDH include Level II case management services within managed care plans' responsibility. Given HMOs' strengths in delivering medically-oriented care, they are in a good position to provide Level II case management services to patients whose predominant needs are medical in nature. However, for clients whose primary needs are focused on reducing risky behaviors or who require interventions from social services

agencies, managed care plans should be encouraged, at least in the near term, to contract with Title V-funded community agencies for the provision of Level II case management services. This approach acknowledges the fact that managed care plans tend to be less experienced than community agencies in working with clients at psychosocial risk, while also allowing them the opportunity, over the long term, to develop the capacity to provide Level II case management services to this population. It also offers an opportunity for Title V-funded community agencies to continue operating within a managed care environment as contractors to managed care organizations, at least for a few years; the Texas waiver application specifies that organizations deemed "essential community providers" would not be allowed to be excluded from managed care plans' networks for the first three years of the five-year implementation period.

With regard to financing arrangements, it is recommended that, in the short term, TDH compensate plans for this more intensive level of case management through a supplemental premium. This additional payment would be paid on top of the basic capitation rate, when plans determine and report to the state that an enrollee needs this level of care. Over time, as the state becomes more familiar with the prevalence of clients requiring Level II case management services and the costs associated with serving them, it should work toward including these costs in prospectively-set capitation rates. A scenario illustrating how this approach could be implemented in a situation involving a chronically ill child is presented in Case Example #2 below.

3. Level III Case Management

Level III case management is appropriate for individuals with medically and/or socially complex needs and whose families do not have sufficient knowledge, skills, or support to access needed health and social services. Furthermore, these families do not have the skills necessary to manage their children's conditions within the home and community environments. Families receiving Level III case management require frequent intervention, education, and support.

TDH has two options for how to deliver and pay for Level III case management services under RBMC arrangements:

Case Example #2:
Level II Case Management Under RBMC Arrangements. Child with Medical Conditions.

Rodney Lowe is a six-year old child with chronic asthma and chronic otitis media. He lives with his father, who works during the day at a local newspaper factory, and two school-aged siblings in Lubbock, Texas. Rodney has frequent asthma attacks, which result in emergency room visits, and takes three different medications including use of an inhaler for his asthma. His chronic ear infections have resulted in hearing loss and subsequent language problems.

Rodney qualifies for Medicaid under the OBRA-89 expansion option. After obtaining Medicaid coverage for his son, Mr. Lowe enrolled Rodney with an HMO. He then met with a benefit advocate who explained the services available through the HMO and provided Mr. Lowe with a list of physicians. After receiving notification from Mr. Lowe of his primary care physician selection for Rodney, the HMO scheduled an initial visit. At this visit, Mr. Lowe expressed his concern about Rodney's hearing loss, noting that Rodney's teachers wanted to have him evaluated by a speech pathologist. He also indicated his concern over how the otitis media might affect Rodney's asthma, which medications were best, and had multiple questions about how Rodney could best be helped.

After the visit, the physician contacted the HMO benefits office and requested that a nurse case manager assist Rodney and his father. The case manager reviewed Rodney's situation with the primary care provider and scheduled an appointment after working hours to visit Mr. Lowe and Rodney in their home. At this visit the case manager:

- Conducted an interview and assessment of Rodney's needs and Mr. Lowe's concerns;
- Reviewed past medical history and school records with Rodney's father;
- Reviewed the primary care provider's recommendations for a change in medications and the need for an evaluation by a speech pathologist;
- Provided Mr. Lowe with a list of qualified speech pathologists who were part of the plan's network and explained which providers focused on children;
- Informed Mr. Lowe of the side-effects of the medications for Rodney's asthma and assured him that any treatment recommended by the speech pathologist would be reviewed by the primary care doctor and approved only after evaluating the effects of the treatment on the child's asthma;
- Informed Mr. Lowe that communication will occur between the primary care provider and the school system as well as the speech pathologist; and
- Developed an interim care plan based on Mr. Lowe's desires and the primary care physician's recommendations.

The case manager also scheduled an appointment with the speech pathologist that Mr. Lowe selected. After evaluating Rodney, the speech pathologist determined that speech therapy was needed and could be provided through the school system. The case manager communicated this finding to Mr. Lowe and the school system, and an educational plan was then developed for

Case Example #2 (cont.)

Rodney which considered his need for oversight concerning the administration of asthma medications. The case manager monitored the child's progress on a monthly basis.

After two months, it was determined that Rodney was benefiting from the therapy. A school nurse monitored his asthma attacks and informed the case manager whenever any problems arose with the child's asthmatic condition. The case manager relayed this information to Mr. Lowe and the primary care physician, and also advised Mr. Lowe on the appropriate administration of Rodney's asthma medication, which had been determined to be a problem during the home visit interview. After three months the child's needs appeared to have been met, Mr. Lowe better understood how to administer the asthma medications, and he also recognized that the speech therapy did not interfere with the asthma medications. The case manager closed the child to Level II case management and provided Mr. Lowe and the primary care physician with a phone number to call in the event that problems occurred in the future.

A second scenario illustrating the suggested approach for implementing Level II case management under RBMC in the case of a child with psychosocial risks appears below, as Case Example #3.

Case Example #3:
Level II Case Management Under RBMC Arrangements. Client with Psychosocial Risk Factors.

Theresa is an 18- year-old single mother who was discharged from her hospital's postpartum unit within 24 hours of the birth of her infant, Natalie. Theresa's mother lives in Chicago and has not had any contact with her daughter for eight months.

Theresa's prenatal care and hospitalization was covered by Medicaid. Theresa had signed a form that indicated she was to be enrolled in an HMO, although she was not aware of the implications of the form she signed. She was also unaware of the state's policy of automatically assigning newborns of enrollees to the HMO unless the mother selected another provider for her child.

Theresa has had numerous difficulties as a new parent, including trouble finding adequate housing for Natalie and herself and paying for diapers and other infant care items. Since she had not received any infant care instructions before leaving the hospital after giving birth, Theresa also felt unprepared to deal with Natalie's feeding problems and frequent skin rashes. She also had not received any notices from the HMO about the well-baby schedule and, therefore, did not know that she should bring Natalie in for a six week check-up. At two months of age, Natalie developed a fever and a generalized rash. Theresa had to borrow money from a neighbor to pay for a cab to take Natalie to the emergency room. The emergency room physician decided to admit Natalie for several reasons; she believed Natalie might be septic, was concerned about Natalie's lack of weight gain, and also questioned whether Theresa's parenting skills were adequate.

The emergency room verified the Medicaid eligibility and determined that Natalie was enrolled in an HMO. The HMO authorized the emergency room visit and hospitalization. A representative from the HMO called the admitting physician and discussed the dynamics of this case. The HMO representative recognized that Theresa and Natalie required a combination of medical and social services, and decided to request case management assistance from a local

Case Example #3 (cont.)

health department that was under contract with the HMO to provide case management services in return for a fixed monthly fee.

Three days after Natalie was released from the hospital, the social worker from the local health department who was assigned to Theresa and Natalie's case conducted a home visit. During the visit, she conducted a child and family assessment and worked with Theresa to develop a care plan. Over the following weeks, the social worker conducted the numerous activities in accordance with the care plan, including:

- Referring Theresa and Natalie to a local child development clinic which also offered parenting classes;
- Arranging for improved subsidized housing;
- Providing Theresa with a booklet on child development including the periodicity schedule for well-child exams;
- Arranging for a representative from the HMO to explain the HMO benefits and policies to Theresa as well as the scope of services and how to access those services;
- Arranging for a local agency to donate a diaper service for a period of three months; and
- Discussing Theresa's employment and educational plans with Theresa and provided some options with respect to child care.

Although Theresa began to take Natalie to her scheduled well-child check-ups at the HMO, she expressed concern to the pediatrician that she may not be able to continue to care for Natalie. She also indicated to the social worker that she was not ready to be a mother. The social worker notified the child development clinic that Theresa was having concerns about her caretaking abilities so that Theresa would receive additional training and counseling.

A few weeks later, a neighbor of Theresa's called the police when she continued to hear Natalie cry over a several hour period. The police arrived at Theresa's apartment and discovered a letter from Theresa indicating that she could no longer care for Natalie and wanted to make sure that the baby had a good home. Natalie was placed in the state's custody. The social worker notified the HMO that Natalie would be transferred to a foster care home on a temporary basis and that the foster care home would be located outside the HMO's geographic region. She also notified the Medicaid agency that Natalie would be transferred to another area and would need to be assigned to another managed care plan. Finally, she transferred Natalie's records to the foster care social worker, who determined that Natalie should be assigned to an HMO that had recently developed a social services case management system within its plan. While Natalie was in the state's custody, the foster care social worker maintained close communication with the plan's case manager to monitor the child's situation.

- First, TDH could carve out Level III case management services from the basic benefit package for which managed care plans are responsible and have TDH Title V-funded regional staff or contracted agencies provide the service. If Level III case management is carved out from managed care plans' responsibilities, the state will need to specify risk-assessment and referral criteria in its contracts with plans. Under this option, the Medicaid agency could purchase case management services from Title V or a Title V-funded agency and reimburse providers for the service on a fee-for-service or capitated basis.

- A second option would be to make managed care plans responsible for providing Level III case management services, either in house or through its contracted network of providers. In its RBMC contracts, TDH would need to develop contract language that specifies the case management functions and provider qualifications for Level III case management. Furthermore, Level III case management services could be included in the plan's capitation rate or be paid through a supplemental premium. If case management services were included in the capitation rate, this rate would need to be adjusted to account for the increased cost of this service based on the activities that have been specified for Level III case management. There would also need to be some adjustment for the anticipated duration of Level III case management. If the state elected to reimburse Level III case management through a supplemental premium to plans, in lieu of an all-inclusive capitation rate, plans would receive an extra payment after determining that one of its enrollees needed Level III case management. This approach would provide a direct financial incentive to managed care plans to appropriately provide Level III case management activities to medically and/or social complex individuals.

The pros and cons of each of these approaches are similar to those for Level II discussed above. The benefits of having a RBMC plan provide Level III case management include promoting continuity of care among the plan's network of providers and decreasing the potential for conflicts between the plan and the case manager, since the case managers report to and are accountable to the same organization that is providing the care. On the other hand, this model places responsibility for serving persons with multiple and complex psychosocial and medical risks with managed care plans that have little experience in arranging for social, educational, or other services that are not covered in its benefit plan. It would also require plans to make up-front financial commitments to develop case management staff capacity for a relatively small percentage of covered members.

The first option—carving out Level III case management services—has the benefit of placing responsibility for this more intensive level of care with agencies that have more knowledge about and experience with arranging social, educational, and other community-based services. It also fulfills the care coordination provisions related to Title V and SSI child-beneficiaries. On the other hand, this approach raises potential conflicts between the managed care plan and other systems through which case management is being provided since the case management would be less likely to be as coordinated with primary care and other medical services as it might be if it was directly handled by the managed care organization.

- Suggested Approach. Because individuals who require Level III case management have needs that extend beyond the plan's covered benefits or services and require interventions from multiple community agencies, it is recommended that Level III case management be carved out of RBMC plans' responsibility. It is further recommended that Level III case management agencies be reimbursed through a capitated, fixed fee payment for the provision of the carved out services. A capitated reimbursement approach promotes efficiency while also maintaining administrative simplicity for both billing agencies and TDH. It should be noted, however, that implementing this financing approach will involve certain challenges, including:

  - *Developing a payment rate.* In order to develop a capitated rate that accurately reflects the costs of providing Level III case management services, TDH can either build this rate based on the past experience of TDH Title V-funded regional staff and case management contractors or conduct time-and-motion studies and cost-accounting to determine the appropriate rate.

  - *Developing different rates for different providers.* As discussed earlier in this report, PWI case management services are delivered by a variety of provider agencies, including TDH regional offices, hospitals, and parent-run organizations. These different agencies may incur different costs. For example, the agencies employ case management staff with different educational and experience levels. TDH may, therefore, need to develop a range of payment rates that reflect the different costs associated with these different levels of training and expertise.

  - *Leveling the playing field across various case management agencies.* The recommended payment structure does not address a critical problem faced by small case management organizations: the lack of seed money necessary to build staff capacity and finance case manager positions before sufficient funding is obtained through third-party reimbursement. To promote the viability of Texas' public health case management

systems, Title V may wish to offer financial assistance in the form of start-up grants to small organizations that would otherwise be unable to support case management staff during a transition to Medicaid financing. The Title V program may offer a short-term source of funds for this worthwhile purpose.

Case Example #4 illustrates the suggested approach and is provided below.

Case Example #4:
Level III Case Management Under RBMC Arrangements.

Jessica is a three-year old child of a low-income two-parent family with two other adolescent children. The child qualifies for Medicaid benefits and is enrolled in a Medicaid RBMC plan. Jessica has several complex health problems: she is ventilator-dependent, has chronic cardiac and renal problems, and is also developmentally disabled. One of her older siblings is experimenting with drugs and has had multiple school absences. The family has one car that the father uses to get to and from his day job. The mother is pregnant with her fourth child.

Jessica's mother spends most of her day caring for her young daughter. She has difficulty arranging transportation to take Jessica to her multiple specialty visits, a problem that has also partly accounted for her missing several prenatal visits. Her anxiety level has increased over the past several months and she believes "there is no hope."

When Jessica was enrolled in her managed care plan, a risk assessment of her and her family was conducted. Because of the social and health-related circumstances of the family, the plan determined that the child was eligible for Level III case management. The plan then enlisted the aide of a parent-run organization qualified to provide Level III case management services.

After notifying TDH that it had received a referral from the RBMC plan and would be providing case management services to Jessica's family, the parent organization conducted several activities to assist the family. Using the plan's risk assessment findings as a base, the case management agency provided Jessica's parents with informational materials about their child's conditions and were given the names of two other families with children with health problems similar to Jessica's. They also referred Jessica's family to several community organizations that provide respite care, transportation, and assistance with adapting families' homes to accommodate disabled persons' physical limitations.

Level III case management activities were provided to Jessica's family for a period of nine months, during which time the case management agency was paid a monthly capitated rate by Medicaid. The case management activities were coordinated with the RBMC plan and frequent communications occurred between the case manager and the plan's primary care nursing staff. Periodic evaluations indicated that the family situation had improved. At the end of nine months, the family was "closed" to Level III case management, although the managed care plan agreed to make another referral for case management services if periodic evaluations indicated that problems had recurred.

D. Providing Case Management Under Primary Care Case Management Arrangements

Under Primary Care Case Management (PCCM) models, physicians or physician groups are contracted to serve as primary care providers for individuals who enroll in their practice. In the role of primary care provider, physicians are expected to render all primary and preventive care services in-house and, in addition, to serve as "gatekeepers" for any care to be received outside of the primary care setting. That is, the primary care case manager agrees to be responsible for referring enrolled patients to specialists or other providers for additional care when it is deemed by them to be medically necessary. PCCM providers are typically reimbursed on a fee-for-service basis for their provision of primary care services, although partial capitation rates can be developed for such physicians. In addition, primary care providers under PCCM arrangements typically receive a nominal monthly fee (usually $3-$5) for each person enrolled in their care to cover the costs of coordinating patient care; in other words to serve as the patient's case manager.

Like RBMC arrangements, there are pros and cons associated with the PCCM model of Medicaid managed care. Since PCCM providers are generally paid on a fee-for-service basis for most services, inappropriate restriction of services tends not to be a major concern attached to PCCM arrangements as is often the case with RBMC models. In addition, for particularly vulnerable populations such as children with special health care needs, PCCM arrangements offer a less risky version of managed care than the RBMC model, which departs more drastically from traditional fee-for-service arrangements. Furthermore, due to the explicit role of the primary care provider to serve as the medical home and gatekeeper, PCCM arrangements can reasonably be expected to provide care in a more coordinated manner than traditional fee-for-service systems. On the other hand, PCCM models do not hold the same promise for controlling expenditures or fully integrating care as do RBMC arrangements, which tend to have more tightly defined provider networks and operate under capitated reimbursement structures.

1. Level I Case Management

As described above, Level I case management is the least intensive version contained in the proposed case management structure. It consists primarily of outreach and informing functions and is the most appropriate level for families with generally high levels of functioning and ability to access needed services. As with Level I case management under RBMC arrangements, Texas health officials have the option under Medicaid PCCM models of either including this level of case management in contracted providers' responsibilities or contracting separately for this function.

Unlike larger HMO-style managed care organizations, physicians contracted under PCCM arrangements are likely to operate in smaller practice settings (either individual or group practice). Therefore, PCCM providers are less likely to have the organizational resources to provide orientation sessions and supplemental services like supervised child care as described above in the Level I case management scenario for RBMC. For this reason, an argument could be made for contracting separately for outreach, informing, and basic education regarding how to use the service delivery system and the importance of routine preventive care. An example of this approach exists in the State of California, which has long operated county-administered EPSDT outreach units which support physicians by providing families with EPSDT-eligible children information about available benefits, helping them to schedule appointments and arrange transportation, and following up to ensure that needed diagnostic and treatment services are received. EPSDT physicians in California indicate the local outreach units provide an invaluable source of support and assistance in helping to reach children to ensure that they receive needed preventive and other services.

Alternately, Texas could choose to require primary care providers to deliver such informing and outreach services as part of their contracted responsibilities and for which they receive a monthly case management fee. This approach has the benefit of placing responsibility for basic coordination on the primary care provider and of avoiding the need for the development of a separate infrastructure for delivering Level I case management services. Furthermore, this

choice would avoid the costs of staffing outreach units to conduct activities that should already be covered by the monthly case management fee paid to primary care physicians.

- Suggested Approach. Similar to the suggested approach for this level of case management under RBMC arrangements, it is recommended that Level I case management activities be made the responsibility of primary care physicians contracted under PCCM arrangements and, furthermore, that primary care physicians be reimbursed for this activity as part of their monthly case management fee. Monthly case management fees are intended to subsidize the delivery of just the type of informing, outreach, and educational services that are inherent in Level I case management, services that help to improve the appropriate use of routine preventive services and avoid the high costs and inefficiency of inappropriate emergency care. It is, therefore, reasonable for the state to expect that these type of activities will be incorporated, if they are not already routinely a part of, contracted primary care physician practices. See Case Example #5 for an illustration of how this approach could be implemented in a particular example.

2. Level II Case Management

As described earlier, Level II case management involves the provision of information and referral services to families as well as family assessment, care plan development, home visits, support services, and assistance with the arrangement of services. Two groups in particular may require this more intensive level of case management:

- Individuals at risk of poor growth and development due to psychosocial and environmental factors including, for example, poverty, teen pregnancy, living in a single parent household, and history of abuse or neglect; and

- Families with children with chronic health conditions that are generally high functioning but who still need some assistance in planning and coordinating their receipt of multiple services.

TDH has two options in deciding how to provide Level II case management services under PCCM arrangements:

- TDH could decide that Level II case management activities exceed the PCCM provider's responsibilities and capacities and, therefore, should be carved out of the PCCM benefit package. In this case, both a separate delivery and payment system would need to be established for this version of case management. The

Case Example #5:
Level I Case Management Under PCCM Arrangements.

Dr. Pincus is one of three pediatricians in a small group practice. Given the low fee-for-service payment rates that the state has traditionally paid for office visits for Medicaid patients and the high no-show rates typical of Medicaid clientele, the group practice has historically limited the number of Medicaid patients it would serve. However, with the advent of Medicaid managed care statewide and modified payment arrangements—including a small guaranteed monthly payment on behalf of all enrollees regardless of whether or not they are seen in that month—Dr. Pincus convinced her partners that enrollment in the program would benefit the practice. In particular, she successfully argued that pooling the monthly case management fees for all enrollees across the three physicians could finance an additional staff person to function in a case management and support capacity.

Within the next several months, the new case manager initiated the following activities:

- Sending letters to all enrollees new to the practice welcoming them and providing them with a range of information, including their primary care physician's name, telephone numbers to make appointments and to obtain assistance in arranging transportation, directions regarding where to receive emergency care, and a recommended schedule for immunizations and well-child exams;

- Mailing letters confirming appointments and placing reminder calls the day before a scheduled appointment;

- Helping to link patients to needed community resources, including transportation, child care, respite care, and other needed services; and

- Assisting patients with scheduling appointments with specialty providers when referrals for additional services were made.

In addition, during each new patient visit, the case manager spent a few minutes with each family describing the practice and its available services, the role of the primary care physician, and the importance of preventive care. In addition, he began distributing a packet of information that included several educational brochures about available community resources and common childhood problems.

Soon, Dr. Pincus and her colleagues began to realize improvements in several key areas, including better educational materials for patients, an improved kept-appointment rate, and an increase in the number of patients receiving immunizations and well-child exams in accordance with recommended schedules. Importantly, the physicians also began receiving many positive comments from their patients about the orientation information provided during initial visits and the assistance available through the case manager.

Medicaid agency could, for example, pay a health department or hospital-based program for Level II case management services on a fee-for-service, capitation, or salary and expense basis.[7] At a minimum, PCCM provider agreements would need to contain referral criteria or mechanisms to access external Level II case management services.

- Alternatively, TDH could include this level of case management in PCCM providers' responsibility. In this situation, the fee paid to the primary care physician for managing the child's health care and authorizing specialty services would need to be enhanced to compensate the provider for this more intensive level of service.

These two alternatives each offer pros and cons. The second option—including Level II case management in the PCCM provider's responsibility—has the benefit of incorporating case management services within the medical home. On the other hand, PCCM providers are not likely to have the staff capacity needed to provide this level of case management service in an efficient and effective manner. The first option—carving this service out of the PCCM provider's responsibility—responds to this capacity issue and appropriately places responsibility with community agencies that are likely to have more experience in addressing families' multiple needs, including those of a non-medical nature. However, this approach raises the challenge of how to coordinate Level II case management services provided by an outside agency with primary care services provided by the PCCM provider, who must be kept apprised of any needs that may interface with the client's overall health status.

- Suggested Approach. It is recommended that TDH carve out Level II case management services from PCCM providers' responsibilities. Unlike Level I case management, for which PCCM providers can reasonably be expected to perform in exchange for a monthly case management fee, providing the more intensive Level II case management services is likely to significantly exceed the internal capacity of the PCCM provider. Furthermore, community agencies are more likely to have the expertise needed to help clients with multiple needs, many of which are likely to fall outside the purview of the typical primary care physician. With regard to reimbursement for Level II case management, the Medicaid agency or Title V could compensate Level II case managers based on a fee-for-service, capitated amount, or pre-determined salary and expense basis. Despite the challenges involved in implementing a capitation methodology, it is

[7] Payment for case management on a salary and expense basis refers to the Medicaid agency covering on a prospective basis all or a portion of an individual's salary and related expenses. Under administrative case management, current federal regulations permit state agencies to fund individuals' salary and related expenses. This is a different method than retrospectively paying a portion of an individual's salary and related expenses based on time expended on providing case management services.

recommended that TDH reimburse qualified providers a monthly fixed fee for performing Level III case management. A case example illustrating the suggested approach is provided below in Case Example #6.

Case Example #6:
Level II Case Management Under PCCM Arrangements.

Keshia is a six month-old child living in a two-parent family. Keshia's mother, JoEllen, is developmentally disabled and, therefore, receives services from a local developmental services agency. JoEllen has also just learned that she is pregnant with her second child. Keshia's father is a skilled laborer at an oil refinery. Because the family's income is less than 185 percent of the federal poverty level, Keshia qualifies for Medicaid, as does JoEllen by virtue of her pregnancy. When the family received a letter in the mail about changes in the Medicaid program regarding managed care, JoEllen threw it away, not believing that the letter contained any important information. Within 30 days, Keshia was assigned a new doctor, Dr. Good, who would serve as her primary physician within the Primary Care Plan. Dr. Good was not the doctor that Keshia had been seeing up to that time. (JoEllen did not receive a similar letter because her Medicaid eligibility had expired two months after she delivered Keshia, and she had not yet reapplied for Medicaid coverage since her recent pregnancy diagnosis.)

Approximately 60 days after Keshia's enrollment in the Primary Care Plan, Keshia became ill; she ran a high fever and began having seizures. JoEllen called 911 and an ambulance took Keshia to a local emergency room. The baby was subsequently admitted to the hospital for observation. Keshia's assigned physician, Dr. Good, met JoEllen the next day and informed her that he was now Keshia's doctor. JoEllen was unhappy because Keshia already had a doctor that understood Keshia's and JoEllen's needs. However, she didn't take any steps to change physicians at that time.

Dr. Good authorized the hospitalization and arranged for the Children's Hospital in Houston to conduct a series of neurological tests to see if Keshia had a brain lesion. JoEllen was devastated and fearful. Her husband could not take time off of work to take her and Keshia to Houston, and she did not want to travel alone with Keshia; she was afraid that Keshia would have more seizures in the car and that she wouldn't know what to do. JoEllen's case manager from the developmental services agency, Terry, met with JoEllen to provide some immediate support and assistance. Terry also called Dr. Good and explained JoEllen and Keshia's past history and family situation. Dr. Good requested that Terry remain involved during the next couple of months to provide case management services for the family, including helping JoEllen reapply for Medicaid and obtain prenatal care. The developmental services agency was authorized by Medicaid to perform these activities and, for its services, was reimbursed on a monthly, fixed fee basis.

As the family's case manager, Terry arranged for transportation to and from Houston and attended specialty visits with JoEllen. Fortunately, Keshia was found not to have a brain lesion, although she would need to take medication to control her seizures. Terry worked with the doctors to instruct JoEllen in the proper administration of the medication and how to manage Keshia's seizures. Because JoEllen wanted Keshia to continue her care with her previous pediatrician, Dr. Higgins, Terry also worked with the local Medicaid agency to change Keshia's primary care physician assignment. Once this was accomplished, Terry provided Dr. Higgins with an update on Keshia and JoEllen and informed him that she was closing Keshia to "active" case management, but that she should be contacted if additional support was needed in the future. However, she continued to work with JoEllen throughout the duration of her pregnancy to ensure that she received needed services.

3. Level III Case Management

As noted previously, Level III case management activities are designed for individuals who have medically and/or socially complex needs and whose families have insufficient knowledge, skills, or support to access needed services, both of a medical and non-medical nature. Families receiving Level III case management require frequent and ongoing intervention, education, and support.

The options presented above for providing Levels I and II case management under PCCM models do not apply for Level III case management. The intensity of Level III case management services is clearly beyond the capacity of PCCM providers. For example, as discussed in Chapter III, Level III case management providers would be expected to conduct frequent visits, possibly at the client's home, for a duration of six months to one year. This activity, along with the many others associated with this level of care, goes significantly beyond the typical responsibilities and capacities of a PCCM physician.

- Suggested approach. For the reasons stated above, it is recommended that Level III case management be carved out of PCCM providers' responsibilities. Unlike Level I case management, this level of care exceeds the capacity of typical PCCM providers. Furthermore, families eligible for Level III case management often require assistance from multiple community agencies with which the PCCM provider is not likely to have much practical knowledge or experience. It is recommended, instead, that this level of case management be performed by Title V-funded TDH staff, its contracted providers, or other community providers. However, to ensure that PCCM clients have access to Level III case management, PCCM providers may need to perform or arrange for a risk assessment. At a minimum, the PCCM provider agreement with the state Medicaid agency should specify referral criteria for PCCM providers to use in judging whether or not to refer a patient to TDH or its agents for Level III case management. To promote efficiency and administrative simplicity, it is recommended that TDH develop and reimburse qualified providers a monthly capitated rate for Level III case management. A scenario illustrating how this approach could be implemented for a sample client is provided below in Case Example #7.

Case Example #7:
Level III Case Management Under PCCM Arrangements.

Joe is a 14-year-old child who has suffered a spinal cord injury. Because of the debilitating nature of his injury, Joe qualifies for SSI and Medicaid. Upon his enrollment in Medicaid, Joe was assigned to Dr. Oswell as his PCCM provider. On his first visit with Joe and his parents, Dr. Oswell identified the need for Level III case management. He discussed the services offered by Level III case management providers, and the family agreed to receive this service. Based on his conversation with the family, Dr. Oswell referred the family to a local agency that had an ongoing relationship with the school system and which had an agreement with the Medicaid agency to be reimbursed for Level III case management on a monthly capitated basis.

During the family's first visit with Robert, their new case manager, a family support and care plan was developed. Robert indicated that Dr. Oswell would be asked to review the care plan and would also be regularly updated on Joe's progress. In addition to conducting frequent home visits to talk with Joe and his parents, Robert helped to arrange for a variety of services. For example, he arranged for a state-subsidized contractor to determine how the family's home could be adapted to meet Joe's physical limitations, helped arrange for a handicapped-accessible van to transport Joe to school and medical appointments, and worked with the school to allow Joe to receive therapy and other health-related services in the school setting. Robert maintained close contact with Joe and his family for six months as these arrangements were put in place, and then began to taper off visits as Joe's routine became successfully established. Robert formally closed Joe to active case management nine months after its initiation.

E. Summary of Suggested Approaches

Throughout Chapter IV, suggestions have been made regarding how TDH could deliver and pay for Levels I, II, and III case management services under both RBMC and PCCM arrangements. Table IV-I summarizes these suggested approaches.

In brief, it is suggested that TDH require Medicaid managed care providers, including both RBMC plans and PCCM providers, to deliver Level I case management within existing payment arrangements. For Level II case management, HSR suggests that RBMC providers be held responsible for the provision of this service either directly or through their networks of community providers and, furthermore, that they be paid a supplemental premium for providing the service. However, it is recommended that PCCM providers not be asked to perform this service, as doing so would exceed the typical capacity of such caregivers. For Level III case management, it is likely to be most appropriate for this service be carved out of the

responsibility of both RBMC and PCCM providers—as this intervention demands skills and capabilities that typically exceed the capacity of managed care plans' traditional providers—and that it be provided by alternative Title V-funded providers in return for capitated payments.

Table IV-I.
Summary of Suggested Approaches for the Delivery and Financing of Case Management Services under RBMC and PCCM Arrangements.

Level of Case Management	RBMC Arrangements		PCCM Arrangements	
	Service Delivery	**Financing**	**Service Delivery**	**Financing**
Level I	RBMC responsible	Basic capitation rate	PCCM responsible	Basic case management fee
Level II	RBMC responsible, but contracting encouraged	Supplemental premium	Carved out	Capitated fixed fee
Level III	Carved out	Capitated fixed fee	Carved out	Capitated fixed fee

CHAPTER V

Future Roles for Title V

As discussed throughout this report, the Texas health care system is undergoing significant change. Of particular import is the movement to Medicaid managed care, which is altering longstanding service delivery and financing arrangements and traditional roles and practice arrangements of public and private providers. At the same time, Congress is debating fundamental changes in the financing structure of public programs and considering replacing the entitlement status of many programs with capped block grants. These changes will have a dramatic impact on how health and related services will be delivered in the future.

As a key component of its health system, Texas' Department of Health is necessarily undergoing change and planning for the future. In particular, the health care system trends mentioned above are forcing a re-examination of Title V roles, as illustrated by its undertaking of the Title V Futures Project discussed earlier. However, these trends do not point to one clear direction for the Title V program. On one hand, the implementation of Medicaid managed care indicates that Title V should move away from its traditional focus on providing and paying for health services that will be delivered by managed care providers and toward an emphasis on development of core public health activities, defined by the Institute of Medicine as including quality assurance, policy development, and assessment. On the other hand, the prospect of block grants restricting Medicaid eligibility and the scope of services that the program covers suggests that Title V will need to continue to play an important role in maintaining a safety net of services for a potentially larger uninsured population. Whichever force ultimately prevails, however, the Title V program will continue to be responsible for meeting its statutorily-based mandate to assure the health of all mothers and children.

In carrying out this mandate, Title V can expect that providing and overseeing the delivery of case management services will be a priority regardless of whether the agency assumes a broader core function role or a continued direct service role. For example, in assuring that health systems provide services of high quality, Title V can play a critical role in the development of guidelines of care for the delivery of case management services. Similarly, if needed, it may continue to provide case management services to underserved populations through its regional department infrastructure. By identifying a strong role for Title V in shaping the way case management services will be delivered in managed care settings, this report places more emphasis on the broader systems development role; however, the proposal also recognizes that TDH regional office staff and contractors may continue to play an important role in delivering case management services for high-risk populations.

The remainder of this chapter builds on the issues explored above regarding TDH's future roles by identifying a range of potential activities for TDH staff. In the first two sections, focused on TDH central and regional office staff, respectively, a range of activities to assure the availability of high-quality case management and other services are proposed. The third section focuses more specifically on several short-term objectives that TDH will need to address to implement the case management proposals included in this report.

1. Future Roles for Central Office Staff

In the future, central office TDH staff can play a variety of roles in shaping systems of care broadly and case management systems specifically. The following list of potential activities assumes that Texas will continue to expand its development of Medicaid managed care systems and that TDH will increasingly embrace the vision of the Institute of Medicine by enhancing its capacity to perform core public health functions. These activities include:

- Determining the availability of local, state, and federal funds for case management;
- Monitoring the policy directions of federal and state executive and legislative branches of government concerning case management;

- Identifying the organizational model that best suits TDH's role in administering the proposed case management system;

- Conducting staff and organizational functional analyses and determining the future functions of central office staff based on policy directions concerning managed care and case management, which may include policy development (e.g., contract language for managed care contracts), data collection and dissemination, quality assurance for Medicaid managed care, evaluations of Medicaid managed care and case management, and staff training;

- Determining staff capacity and capability to carry out case management functions identified in this report;

- Determining which existing functions can be eliminated or contracted to other entities;

- Analyzing the geographical areas to be covered by PCCM and RBMC models and determining case management needs based on the capacity of Medicaid managed care models;

- Developing funding mechanisms to provide needed case management services;

- Developing and refining case management operating instruction and training materials for case managers and conducting training activities;

- Developing case management quality assurance strategies and plans, in conjunction with the Medicaid agency, for Medicaid managed care models; and

- Developing data collection and reporting mechanisms to monitor the delivery of case management services by managed care providers.

2. Future Roles for Regional Office Staff

In addition to refining the roles of central office staff, TDH officials must clarify future roles for regional office staff. As "arms" of the state, regional office staff should, like their counterparts in the central office, assume an enhanced role in performing core public health functions. However, because regional office staff are more closely involved with direct service delivery systems, they are more likely to continue being involved with providing case management services, at least in the short term. Over the longer term, however, TDH should plan to diminish its role in this function. The following list presents a range of alternative roles that regional office staff might assume in fulfilling broader systems development responsibilities:

- Providing technical assistance to managed care providers and organizations in the implementation of proposed case management activities;

- Providing technical assistance and information to RBMC and PCCM providers concerning the availability of community services;

- Providing technical assistance to community programs in negotiating and executing appropriate contracts with managed care providers for the delivery of case management and other services;

- Determining the need to provide direct services and case management for uninsured or underinsured individuals in a particular geographic area;

- Conducting local needs assessments of individuals and communities concerning health, educational, social, and other services;

- Providing information to RBMCs and PCCM providers concerning health status and system indicators in a given geographical area (e.g., infant mortality, teen pregnancy rates); and

- Working with RBMCs and PCCM providers to develop mechanisms to improve health status and system indicators.

3. Short-Term Steps for Implementing the Case Management System

The above discussion identified numerous options for the Title V agency to enhance its role in developing and assuring a high-quality system of case management. In addition to these broad roles, however, there are several specific steps that TDH will need to take to implement the case management proposals included in this report. These include designing a risk assessment instrument and system, developing referral protocols, developing detailed service delivery protocols, and establishing provider criteria and certification processes. Each of these steps is discussed in turn below.

a. Designing a risk assessment instrument and system

Designing a child and family risk assessment process to identify clients who need case management services, as well as the appropriate level of services for each client, is a critical first step in establishing an efficient and effective case management system. Accomplishing this goal will involve several challenging steps, including:

- Determining the content of the risk assessment tool. In designing an assessment tool to ensure that clients receive risk-appropriate care, it is critical that not only medical but psychosocial risk factors be identified by the assessment instrument, representing a significant departure from the assessment approach traditionally utilized by proprietary managed care systems. To identify the specific content of the risk assessment tool, Title V officials will need to explore the current "state of the art" in risk assessment strategies and approaches. This will involve reviewing the health services research literature as well as existing risk-assessment instruments and processes used in Texas and other states. South Carolina and Florida, for example, use risk assessment instruments for prenatal and infant care that include medical as well as social and economic factors; these tools may offer viable approaches for adaptation by Texas. In addition, Title V officials will need to determine what individual or combination of risk factors would qualify a client for varying levels of case management. Finally, Title V will need to identify strategies for engaging other agencies, providers, families, and additional key stakeholders in the development, approval, and field-testing of risk assessment instrument.

- Determining the "universality" of a risk-assessment process. Ideally, Title V will develop and promote a risk assessment system that will be used statewide and consistently across provider systems. However, given the state's rapid movement to managed care and managed care's general inexperience with risk assessment systems that focus both on psychosocial and medical factors, Title V should focus in the short term on implementing an effective risk assessment system in the Medicaid managed care setting.

  Texas has several options in deciding how to implement risk assessment procedures in the managed care environment. Policies may place either fewer or greater controls upon the manner in which managed care plans identify high-risk populations. These options, from least to most regulatory, include:

  - *Allowing managed care providers total flexibility in designing and implementing their own risk assessment protocols.* This is the most *laissez-faire* policy and one that may succeed in attracting plans to participate in the waiver, but may do so at the expense of state control over whether or how risk assessments are performed.

- *Requiring managed care providers to conduct certain types of risk assessments.* Under this option, the state could, for example, require plans to conduct risk assessments to identify pregnant women at risk for poor outcomes or preschool children at risk for developmental delay. This policy stance would help to ensure that important assessments are performed and increase the likelihood that at-risk populations will be identified. However, as it falls short of prescribing exactly how risk assessments are performed, variations between plans' protocols are likely. Further, plans may request higher capitation payments to cover the cost of developing and implementing the risk screen(s).

- *Impose uniform risk assessment forms and protocols.* This option goes further in assuring that consistent assessments will be conducted by all managed care providers by requiring that uniform risk assessments and/or protocols be used by managed care providers. Plans, however, may resist such a policy, arguing that it infringes too heavily on their flexibility and practices.

- *Requiring that certain types of risk assessments be performed by an outside agency*. This option presumes that managed care providers are not equipped to perform sufficiently sensitive risk assessments of high-risk clients and that performance of assessments by outside agencies, such as local health departments, will best ensure that consistent, high-quality assessments will be performed. However, this approach will be more costly to implement (since the outside assessment process would need to be financed separately from the plans' capitations), may potentially be duplicative (since plans would most likely need to do an initial screen to see who needs to be referred out for further assessment), and is likely to raise controversy regarding managed care providers' obligation to follow plans of care developed an outside agency subsequent to its risk assessment.

In choosing among these options, Title V officials will need to collaborate with Medicaid to determine the most viable approach for Texas. Considerations of staff capacity both within and external to Medicaid managed care agencies will be among the many factors that will need to be considered. In addition, depending on the approach that is chosen, contract language outlining managed care providers' responsibilities with regard to risk assessments will need to be developed, and training would need to be implemented for managed care providers and their staff. Finally, even if the state ultimately decides not to mandate a particular assessment system, it would be appropriate for Title V, within its systems development role, to aggressively promote appropriate methods for assessing risks so as to assure risk appropriate care.

- Monitoring implementation of the risk assessment process. Another important role for Title V, and one that is in line with its effort to fulfill its core

public health function responsibilities, is to monitor the implementation and ongoing quality of the risk assessment system. This role could involve working with Medicaid to identify appropriate data collection and reporting mechanisms, serving on managed care quality assurance review panels, and interviewing providers and families to assess the efficiency and effectiveness of the assessment process.

b. Developing referral protocols

This report provides basic guidance regarding the entities that should be responsible for providing case management services. Depending on the level of case management and model of managed care (RBMC or PCCM), recommendations have been made either to include or carve out case management services from managed care providers' responsibility. Once TDH has made final decisions regarding how case management services will be delivered in different managed care settings, as well as who will conduct risk assessments, specific protocols will be needed to identify providers' roles and responsibilities relative to one another. In particular, specific protocols indicating the conditions under which providers should either deliver or refer clients out for case management services will need to be developed. Furthermore, these protocols will need to identify what types of agencies may serve as referral providers when certain risk factors are identified. For example, Title V may want a social worker to assume primary responsibility for providing case management services in cases involving psychosocial issues and a nurse to fulfill this role in for clients with significant medical needs.

c. Developing service delivery protocols for case management services

The development of detailed protocols describing the content and rules for providing case management services remains an important step in implementing the proposed case management system. This report has provided general guidance regarding the activities that could be included under each of Levels I, II, and III case management and for whom each level of service should be appropriately targeted. More specific Title V protocols can be developed for these services once final decisions on eligibility criteria and case management activities for each level are decided by Title V. These Title V protocols should specify:

- The purpose, goals and objectives of the case management services;

- The criteria defining eligibility for Levels I, II, and III case management services;
- The specific activities of each level of case management;
- Rules regarding where case management services should be provided and under what circumstances;
- The frequency with which each level of case management services should be delivered;
- Criteria for determining how long clients should receive case management services;
- Requirements for coordinating the delivery of case management with children's primary care providers, if the case management provider is different from the primary care provider; and
- Requirements for documenting service delivery activities and reporting such activities to appropriate state agencies.

As a starting point, Texas may wish to structure its protocols after the operating instructions developed for COPC case management. In addition, it would be instructive to study the protocols developed for other states' case management programs.

4. Establishing Provider Qualifications and Processes for Certification

An additional implementation step that TDH Title V will need to undertake is to build on the guidance presented in this report and establish specific criteria by which providers can qualify to serve as case managers, as well as a process for certifying providers for each level of case management. In cases where the primary care provider will also be responsible for delivering case management services, a separate certification process will not be necessary; needed qualifications for providing the required levels of case management should be incorporated into the primary care provider certification process. However, Levels II and III case management will most often by provided separate from the managed care organization and, therefore, will involve this additional step.

Certification of case management providers could occur through an "open" application or a competitive request-for-proposals process. In either of these processes, Title V April 29, 1996 will want to establish criteria that demonstrate providers' capacity to deliver case management services in a high quality manner. In particular, state officials may want to consider requiring providers to meet the following criteria:

- Demonstrate experience serving disadvantaged populations and an understanding of the concept and process for delivering case management services;
- Demonstrate the capacity to provide case management services according to the protocols established by the state, including the ability to provide home visitation services as appropriate;
- Demonstrate linkages to relevant social, health, educational and other service providers in their communities;
- Possess physical facilities that are comfortable, safe, clean, accessible, and meet legal requirements; and
- Generally, provide assurances that they will respond promptly to referrals for case management services, provide for weekend and after-hours emergencies, arrange for bilingual services and transportation if indicated, maintain a confidential recipient records system, and conduct ongoing communication with each eligible client's primary care physician.

A provider application or bid could serve as the sole basis upon which a decision is rendered regarding whether or not a provider qualifies to participate in the case management program. Alternatively, written applications or bids from providers that appear capable of rendering case management services could be followed up with a site visit by appropriate state officials to ensure that a provider has adequate service delivery capacity.

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As health care systems continue to undergo radical change, clients are likely to face significant challenges in understanding and negotiating new service delivery systems and arrangements. Case management can provide critical assistance to clients in adapting to these changes and in using health care services in a more appropriate and efficient manner. This analysis reflects TDH's recognition of the potential for case management services to play an important role in achieving these goals.

This report has identified a range of strategies for adapting Texas' case management systems to the state's changing health care environment. Specifically, a proposal for establishing several discrete levels of case management services to meet clients' varying needs has been presented. Furthermore, strategies for integrating each of these levels of case management into both risk-based managed care and primary care case management arrangements have been discussed in detail. Finally, this report identified a range of possible future roles for Title V central and regional office staff, as well as several critical short-term steps needed to implement the recommendations included in this document. It is hoped that this guidance will be helpful to Texas officials as they work to improve case management systems during this time of change.

By identifying case management as the focus of this federally-funded technical assistance effort, TDH has demonstrated its commitment to ensuring that its many clients will receive risk-appropriate care in the state's increasingly managed care environment. TDH should be applauded for taking this leadership role in designing systems of care to meet this important challenge.