MEDICAID Case Management and Supports Coordination

Seminar for Detroit Wayne MHA Providers

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Agenda Review

- Medicaid Basics

- History Lesson

- Managed Care

- 1915(b)(3)s

- "case management"

- Distinctions among three kinds of case management

- Use of Supports Coordinator Assistants & Service Brokers

- Reporting/billing TCM, SC and HSW SC

- Your Questions

Medicaid Basics

- Medicaid *State Plan* services
  - Those required of every state* (EPSDT, labs, dr. visits)
  - And, optional services* (rehab, personal care)

- Medicaid *Fee for Service*
  - Enrolled provider delivers a service and bills the State-defined fee for that service.* Incentive: bill more

Medicaid Basics

- Medicaid *Managed Care*
  - Federal/State Goal: reduce spending, increase access to and quality of services
  - The payment is made to providers through managed care organizations (MCOs)
  - State pays MCO per member or enrollee/per month; MCO manages within amount paid no matter the demand from beneficiaries; if the demand is less than payment, MCO keeps the difference (i.e., profit). Incentive: well patients reduce demand

Medicaid Basics: Waivers

- Medicaid *Waivers*: waive certain sections/requirements of the Social Security Act
  - 1915(b): managed care
  - 1915(c): home and community based services as an alternative to institutional care or nursing homes * [HSW, Children's, Autism, Children with Emotional Disturbance, MIChoice in Michigan]. All of these are "slot-based"*
  - 1915(i) converts state plan services to home and community based,
  - 1915(j) Independence Plus Waiver
  - 1915(k) Community First Choice Waiver

Medicaid Basics: Michigan

- State Plan medical services via managed care organizations called Medicaid Health Plans (MHP)

- Beneficiaries must have choice of MHP in which to enroll, therefore there must be at least two in a service area [there are rural exceptions]

- State Plan behavioral health/DD services and1915 (b)(3)s via managed care organizations called PIHPs, who are paid on a "per eligible/per month" basis. They are responsible for meeting the mental health needs (beyond basic MH OP benefit) for all eligibles in their service area. Unlike MHPs, PIHPs do not profit when payments exceed demand, but must use the excess funds within a specified percent ("risk corridor") on services in the next FY*

- Habilitation Supports Waiver/1915(c) waiver and Autism waiver via PIHPs, who are paid on a per waiver enrollee/per month*

- Other two 1915(c) waivers (children's) via Fee-for Service arrangements with CMHSPs

Medicaid Basics: Definitions

- *Entitlement*: Medicaid beneficiaries, depending upon their *benefit program* are entitled to certain *types of covered services* in their benefit programs as long as the service(s) is *medically necessary*: the treatment is suited to the condition as determined by a clinician, and will help the beneficiary achieve his/her treatment, rehabilitation or habilitation goals*

- *Benefit program*: determined at enrollment into Medicaid, or subsequent assessment and dependent upon diagnoses, age, income, pregnancy, incarceration, etc. Examples are PIHP, SED, HSW, NH, MIChoice, MOMs

Medicaid Basics: Definitions

- *Types of Covered Services:*
  - 13 main benefit categories, including medical care, emergency services, pharmacy, mental health
  - 99 medical service types, including medical care, surgical, dental care, hospitalization, transportation
  - There is one Mental Health service type

- Every Medicaid beneficiary is categorized by Benefit Plan and Covered Service Type. PIHP beneficiaries will likely have other benefit plan eligibility, such as Medicaid Managed Care (MMC) + PIHP + 1915(b)(3); or MMC + HSW + PIHP State Plan + 1915(b)(3); or PIHP + Healthy Michigan Plan

Medicaid Basics: Definitions

- *Medically necessary specialty services*: MH, IDD, and SUD supports and services that are:
  - Necessary for screening and assessing the presence of a condition, and/or
  - Required to identify or evaluate a condition, and/or
  - Intended to treat, ameliorate, diminish or stabilize symptoms of a condition, and/or
  - Expected to arrest or delay the progression of a condition, and/or
  - Designed to assist the attainment or maintenance of a sufficient level of functioning in order to *achieve goals of community inclusion and participation, independence, recovery or productivity*

History Lesson: Michigan's Medicaid MI/DD/SUD Services and Supports

- Medicaid FFS: incentives to bill, policy requirements for minimum CM visits per month
  - AIS/MR program: multi-disciplinary teams*
  - Habilitation Supports Waiver (1988)*
  - People with MI moved from institution to community

- Experience with CSLA (1991-94)*:
  - Need support for community membership, jobs in regular workplaces, relationships
  - Depending upon the person, may not need the intensity or frequency of case management
  - Tested theories of PCP, choice and control, self-determination

History: Michigan's Move to Managed Care

- Early 1990's pilot use of Medicaid managed care:
  - Intensive crisis stabilization
  - ACT

- 1996-98 development of plan to convert all of BHDD Medicaid services, including the HSW, to managed care

Moving Toward Managed Care

- Learned from HSW, CSLA, ACT, intensive crisis stabilization:
  - Flexible array of services facilitates community living and working
  - Use of paraprofessionals relieves clinicians to do clinical work
  - Let person-centered planning dictate amount, scope and duration of services (including CM and SC) depending upon the individual's preferences, needs, existing supports*
  - People tend to use less amount, scope and duration of services under managed care and when they have *choice and control*, even while improving functioning, or making progress toward recovery

Developing a Managed Care Plan

- In order to develop support services that were a complement to Medicaid State Plan clinical and treatment services:

  - The State aimed to develop more flexible community-based service arrays for two populations: MI and IDD – there were even separate work groups
  - IDD workgroup took the CSLA and HSW service arrays, that included supports coordination, and added housing assistance
  - MI workgroup relied more on the State Plan services, like ACT and clubhouse, and added a few flexible services like skill building, supported employment and community living supports. They did NOT add supports coordination as they believed case management was more appropriate

Negotiated with Feds for a Flexible Array of Services via Managed Care

- State worked with feds (then HCFA, now CMS) to find the proper authority under the Social Security Act through which to legitimately offer these services via managed care: 1915 (a)(1)(A) *allowed* managers (then Prepaid Health Plans, now Prepaid Inpatient Health Plans) to provide them. However, beneficiaries did not have a *right* to due process if the services were denied, reduced or terminated

- Once Michigan's 1915(b) or *managed care* waiver for *specialty services and supports* (i.e., behavioral health and IDD), with its two flexible service arrays, was approved by the feds, the State worked with PHPs (i.e., via contract) to encourage them to offer the services to their recipients

Balanced Budget Act of 1997

- Passage of the Balanced Budget Act (BBA) in 1997 brought about a sea change in Medicaid managed care. "Subtitle H, Medicaid" of the BBA was a result of numerous Congressional investigations and hearings about the nightmares that patients were experiencing under Medicaid managed care. While a good deal of the complaints focused on the *medical* services, Congress did not distinguish between medical and behavioral health or developmental disabilities services when it issued subsequent final managed care rules under the BBA

- BBA:
  - Changed PHP to "PIHP"
  - Beneficiary protections: choice, information for beneficiaries, rights for due process when services are denied, reduced, delayed or terminated
  - Quality Assurance standards

2002 Renewal of 1915(b) Waiver

- State and Federal negotiations resulted in:
  - Requirements to move to encounter data reporting, and
  - Move from using 1915(a)(1)(A) to 1915(b)(3):
    - Requires that service array is an *entitlement* when beneficiary meets certain conditions
    - Blended the service arrays into one for all, added substance abuse services
  - Added:
    - Definitions of Goals that meet Intents and Purpose of "b3" Supports and Services
    - Criteria for Authorizing "b3" Supports and Services

1915(b)(3)s

- Goals that meet intents & purposes of "b3s"
  1. Community Inclusion & Participation: the person uses community services and participates in [integrated] community activities the same way as does a typical community citizen
     - Examples: recreation, shopping, socialization, and civic activities*
     - More real life examples?

1915(b)(3)s

- Goals that meet intents & purposes of "b3s"
  2. Independence: person has freedom from another's influence, control and determination. Person defines the extent of "freedom" during person-centered planning
     - Examples: living on their own (with or without supports, room- or house-mates), controlling their own budget, what and when to eat, what and when to watch TV, when and how to bathe, when to go to bed and get up*
     - More real life examples?

1915(b)(3)s

- Goals that meet intents & purposes of "b3s"
    3. Productivity: person is engaged in activities that result in or lead to maintenance of or increased self-sufficiency
        - Examples: going to school [in an integrated setting] for school-aged children and young adults (who would otherwise be going to college); working [in an integrated setting] and receiving at least minimum wage; and volunteering [in an integrated setting]*
        - More real life examples?

1915(b)(3)s

- Criteria for Authorizing "b3" Supports & Services
  - Medicaid bene is eligible for specialty services and supports,
  - Service(s) are identified during PCP,
  - Service(s) are "medically necessary" as defined in MH Chapter of Medicaid Provider Manual, AND
  - Service(s) are expected to achieve one or more of the goals identified in the IPOS*
  - Additional criteria as defined by the "b3" service description*

"case management" Core Functions

- Regardless whether it is "Targeted Case Management", "Habilitation Supports Waiver Supports Coordination" or "1915(b)(3) Supports Coordination" there are common *core functions* that are expected to be provided, as needed, to the beneficiary:
  - Assessment
  - Planning, development of an IPOS via PCP
  - Linking/coordinating with services and supports*
  - Advocacy with access to entitlements
  - Monitoring

"case management"* Tasks

- case management *Tasks* (as needed and desired by bene via PCP):
  - Determine (i.e., assessment) desires and needs of bene*
  - Supports and services desired and needed are identified and implemented*
  - Assist bene to identify allies to assist in PCP and facilitate them getting there*
  - Address housing and employment issues*
  - Assist bene to develop social networks*

"case management" Tasks

- More *Tasks*:
  - Schedule meetings and appointments (e.g., PCP, community services, medical)
  - Assure PCP is done, and that independent facilitation is offered and described
  - Encourage the use of natural and community supports*
  - Monitor the quality of the services, <u>and</u> the health and safety of the bene

"case management" Tasks

- More *Tasks:*
  - Assure that the bene's income and benefits are maximized*
  - Inform the bene about self-determination; if chosen, assure that the proper supports for its success are in place*
  - If individual budget is used, monitor to assure that services are not under- or over-utilized*
  - Document...everything
  - Review plan of support at intervals determined via PCP

"case management" No-No's

- CMs and SCs may NOT:
  - Deny, terminate or authorize a *covered service**
  - Provide the direct delivery of another *covered service**
  - Duplicate the case management functions that are the responsibility of another agency – e.g., foster care
  - Duplicate the case management functions that are included in another covered service – e.g. ACT, home-based
  - Duplicate the functions that are being performed by a designated supports coordinator assistant or services and supports broker

"case management" Distinctions

- Here are the distinctions among the three "varieties":
    - Needs of the individual
    - Considerations for amount, scope and duration
    - Expectations for applying core functions
    - Staff qualifications

Targeted Case Management

- <u>Needs of the individual</u>: medically necessary for children with SED, adults with SMI, people with DD/IDD, people with co-occurring SMI/SUD who have:
  - Multiple service needs
  - High level of vulnerability
  - Require access to continuum of MH services from PIHP, and/or
  - Are unable to independently access & sustain involvement with services

- <u>Amount, scope & duration</u>: determined via PCP and reflective of the health and safety needs of the bene, adjusted as a result of ongoing monitoring or at the request of the bene. While there is NO set requirement for frequency of contacts, there must be consideration for the vulnerability of the individual when determining amount, scope and duration

- <u>Core functions</u>: [Given the vulnerability of individuals receiving this service, it is expected that all of these functions would be provided by CM]
  - Assessment
  - Planning, development of an IPOS via PCP
  - Linking/coordinating with services and supports
  - Advocacy with access to entitlements
  - Monitoring

- <u>Staff qualifications</u>: QMHP or QMIDD

HSW Supports Coordination

- <u>Needs of the individual</u>: Enrolled in HSW, who would otherwise need an institutional level of care; medically necessary

- <u>Amount, scope & duration</u>: determined via PCP and reflective of the health and safety needs of the bene, adjusted as a result of ongoing monitoring or at the request of the bene. There is NO LONGER a requirement for minimum number of SC visits per month (although at least one HSW service must be provided each month in order for the individual to stay enrolled). However, the vulnerability of the individual needs to be considered.

- <u>Core functions</u>: [It is expected that all core functions will be addressed in the IPOS]
  - Assessment
  - Planning, development of an IPOS via PCP
  - Linking/coordinating with services and supports
  - Advocacy with access to entitlements
  - Monitoring

- <u>Staff qualifications</u>: SC: QMIDD; SC Assistant & Service Broker: minimum of equivalent *experience* (e.g., knowledge, skills and ability) of SC, 18 yrs of age, functions under the supervision of an SC, trained to meet the needs of the bene(s)

1915(b)(3) Supports Coordination

- <u>Needs of the individual</u>: medically necessary for individuals who have goal(s) of community inclusion and participation, independence, and/or productivity

- <u>Amount, scope & duration</u>: determined via PCP and reflective of the health and safety needs of the bene, adjusted as a result of ongoing monitoring or at the request of the bene. There has NEVER been a requirement for a minimum number of SC visits per month. However, consideration of vulnerability, presence of social supports and other factors must be present in the PCP

1915(b)(3) Supports Coordination

- Core functions: [There is not an expectation that all core functions must be performed, whether by the SC or SC assistant or Service Broker]
  - Assessment
  - Planning, development of an IPOS via PCP
  - Linking/coordinating with services and supports*
  - Advocacy with access to entitlements
  - Monitoring

- Staff qualifications: SC: BS/BA in human services field + 1 yr experience with population; SC Assistant & Service Broker: minimum of equivalent *experience* (e.g., knowledge, skills and ability) of SC, 18 yrs of age, functions under the supervision of an SC, trained to meet the needs of the bene

Considerations for Using Targeted Case Management or b3 Supports Coordination

Discussion:

1. Give some [real] case examples of people with SMI who should probably receive TCM; others with SMI who could benefit from SC

2. Give some [real] case examples of people with IDD who should probably receive TCM; others with IDD who could benefit from SC

3. What "tools" would assist the person-centered planning and decision-making about case management?

Relationship between SC and Assistant or Services Broker

- Supports Coordinator Assistants and Service Brokers provide an opportunity for flexibility and economy!

- Use when beneficiary chooses that alternative, and:
  - Has fewer needs: may not require all core functions, and/or requires less frequency of interaction; and/or
  - Has a very involved family, an ally or social network who provide ongoing assistance, including some of the tasks of CM/SC; and/or
  - Has multiple and/or intense needs, but assistant or broker can help with the more basic CM/SC tasks*

Relationship between SC and Assistant or Services Broker

- SC Assistant and/or Services Broker:
    - Trained to meet the supports needs of the individual
    - Supervised by a qualified Supports Coordinator
    - SC and SC Assistant or Service Broker tasks must be explicitly described in the IPOS
    - May not perform, report or bill for tasks that the SC has done, or that were identified as the SC's responsibility in the IPOS*

Considerations for Using Supports Coordination Assistant or Service Broker

Discussion:

- Looking at the tasks on slides #15, 16 and 17:
  1. What tasks could logically be performed by an assistant, or a service broker?
  2. What tasks should not be?
  3. Are there beneficiary characteristics that should be taken into account when person-centered planning considers the use of Assistants or Service Brokers?

Reporting/Billing CM and SC

- Rules:
  - Report/bill only face-to-face contact with bene (the cost of indirect activities may be loaded into the cost of the contact)*
  - Do not report/bill for time spent with bene when he/she is concurrently receiving another covered service (e.g., medical appointment, skill-building)*
  - When an SC Assistant or Services Broker is performing a task, do not report/bill for SC activities that might have occurred at the same time
  - When an SC Assistant or Services Broker AND SC participate in PCP (i.e., Treatment Planning H0032), only report/bill for one
  - Beneficiaries may have only one of: Targeted Case Management, HSW Supports Coordination, or 1915(b)(3) Supports Coordination…therefore only one may be reported/billed

Reporting/Billing Considerations

- Whether or not to report/bill TCM (T1017) or SC (T1016) should be determined during *person-centered planning* when, *based on needs and preferences and whether there are goals for community inclusion and participation, independence or productivity*, one of the two *services* is chosen and that is documented in the IPOS. Reporting/billing of a service must be consistent with the service in the IPOS.

- Utilization Management might challenge the use of TCM or SC depending upon the amount, scope and duration of the service reported. Generally, one would expect to see higher frequency, on average, of TCM than SC. [See above]

- Note: For HSW enrollees, HSW SC (T1016HK) MUST always be reported/billed for SC functions. However, UM might challenge a case where only HSW SC is being billed monthly, and no other service is being utilized. Why?

Additional Questions and Discussion