

Albuquerque Case Management

Medicaid:

Prior to 2007, Case Management was a Medicaid service. CMS reportedly was concerned about the abuse of Case Management, and the service being used in open-ended, non medical-necessity situations. Around 2007, HSD amended State Plan Amendment, removing Case Management as a service, and replacing it with Comprehensive Community Support Services.

(Targeted Case Management is still on NM Fee schedule/SPA, but is limited to the activities of CYFD for children in foster care)

Case Managers typically assisted clients in accessing benefits and resources, coordinating therapy appointments, enroll in educational and/or vocational programs, helped clients apply for SSI, welfare, coordinated housing services, etc. Because many of these needed services weren't explicitly related to medical/mental health conditions and didn't fit well into current medical model billing, there were concerns that Case Management was more of a "social service" than a medical one.

There were concerns at the time that Case Management services were not focused on client's strengths, or on recovery/resiliency. Goal of CCSS was to "teach client to do for themselves," rather than doing for client. There was/is an implicit assumption that some Medicaid/State-funded clients lack initiative or skills to achieve and access services, as opposed to acknowledging the institutional and systemic barriers. CCSS focuses back on the client's deficits, rather than the system's.

CCSS was implemented and restricted, in terms of units/amounts per client, and per agencies authorized to perform service, limited to Core Service Agencies (CSA). Many agencies which could provide Case Management were unable to provide CCSS after the change. Despite significant reductions in out-of-home care and increased Medicaid enrollment, there hasn't been an increase in CCSS capacity, but instead, a reduction.

Core Service Agency (CSA) is a statewide initiative, which limits certain services (including CCSS) to specific agencies, and creates access standards for agency. Many State (non-Medicaid) BH funds are limited to CSA. Initially intended to create a youth "CMHC," the project's scope was extended to the adult system, and to create a "clinical home," which followed clients and ensured coordinated care. CSA was named in regulations and Centennial plan, but no regulations are promulgated for CSA, no current CSA requirements are in place, and access standards are not currently enforced. Per contract, MCO's are limited from naming new CSA's until after 2nd year of Centennial. It is unclear as to how much the CSA system is currently meeting goals and needs.

CCSS is limited to SED/SDMI categories, restricting the service to individuals who meet criteria of serious mental illness. CCSS is available under CYFD and DOH (BHSD) funding, to some individuals who are not Medicaid-eligible, though the CCSS rules are identical to those of Medicaid. Under CYFD-funding, CCSS may be provided to some individuals who meet "at-risk" category.

CCSS allows/includes peer support services, though the extent or full use of this capacity remains low and under-developed.

Comprehensive Community Support Workers (CSWs) are not case managers. CCSS activities specifically address independent living, learning, working, and social and recreational efforts. They embody particular core values:

- Individuals and families are the experts (on their own lives).
- Personal choice should be supported.
- CSW's are collaborators, not directors.
- CSW's demonstrate respect.
- CSW's assist in identifying strengths.
- CSW's assist in identifying solutions to barriers that negatively impact the achievement of previously identified goals.

Comprehensive Community Support Workers (CSWs) may perform the following services and activities:

- Help the client define what recovery means to them individually and set appropriate and attainable goals.
- Assist the individual to develop and coordinate a recovery and crisis management plan.
- Assess, support, and recognize symptoms of a potential crisis situation and early signs of relapse.
- Coordinate programs to assist gaining access to rehabilitative, medical, and other services.
- Support clients in identifying strengths and barriers in developing skills necessary for recovery and resiliency.
- Assist in developing interpersonal and functional skills, including adaptations to home, school, and work environments.
- Assist in developing natural supports in the work place, social, and school environments.
- Assist in building symptom management skills, including behavior management, knowledge of medications and their side effects, and development of skills to take medication as prescribed.
- Assist with practical and vocational skills such as financial management, obtaining & maintaining stable housing, and school/employment performance.
- Monitor progress to determine if services meet the individual's needs.

In Bernalillo/Albuquerque, CCSS providers are:

- Adult- UNMH, St. Martin's, Agave. FQHC's (First Choice, First Nations, and AHCH can bill/provide CCSS but are not for the most part). TLS provides some CCSS for clients within their housing. YDI and Open Skies are both authorized to provide CCSS to adults, but are doing so at limited levels, under initial plan of "transition-aged" individuals.
- Child – UNM (CPH), YDI, All-Faiths, Open Skies.

Case Management remains an activity within some Medicaid services, such as Assertive Community Treatment; MultiSystemic Therapy; RTC; Inpatient psychiatric/medical; TFC, etc., where same-day CCSS billing is prohibited and case management services are expected to occur within umbrella service.

Case management is a covered service under Medicaid waivers for Developmental Disability, and Home and Community Based Services.

Care management, care coordination, and other functions still reside within Managed Care, and provide some limited Case management type functions, but focused solely on accessing health services.

Non-Medicaid:

- AMCI reimburses for Case Management under voucher for substance abuse services – limited to 4 hours per voucher. **Case Management:** is a professional helping process whereby adult and/or adolescent clients participating in a program receive non-counseling services appropriate to their needs either at the program or, if necessary, through facilitated referral. Typical case management services include such activities as helping clients to secure access to educational services, employment services, job training programs, health and welfare services and others based on the secondary needs identified in the client’s initial assessment at AMCI and supplemented with other needs identified during their time in treatment. Case management services can be provided by a primary counselor, a nurse, or a position employed specifically to be a case manager. (See *Case Management Definition, City Minimum Standard,*). **(Maximum of 16 units per voucher)** Time spent for billing for services is NOT a case management function, nor are providing reports to the court for DWI or criminal justice clients, rescheduling appointments, or other administrative activities, or dispensing medications, or writing progress notes or other documentation.
- ATR?
- Value-Added services from MCO – do not currently include Case Management
- HIS facilities can provide CCSS. Unclear if they do so, or provide Case Management instead under separate funding
- Medicare and commercial insurances don’t reimburse for Case Management
- UNM – Pathways and Project Echo: Provide Case Management within these programs, to ???
- Some City grants include Case Management for people enrolled in program, eg. NM Solutions’ Co-Occurring Disorders Programs
- Housing programs such as Supportive Housing, Heading Home have limited Case Management services embedded within.
- Some programs such as DVR, TANF do limited case management
- CYFD provides Case Management often as a part of Child-protective services
- Police and Sheriff’s departments have limited case management (CIT, COAST, etc), though many police officers often end up engaging in limited case management
- Jails have Case managers for discharging
- Case managers at MATS
- Many therapists do case management as a hidden part of billing for therapy
- DD waiver case management

UNM Pathways Program, through Health Sciences Center. Operating since 08. Funded by County Mill Levy, serving approx. 450 clients per year. Provides case management/navigation on “pathways”/tracks of need. Strong model which could be expanded and better publicized.

Gaps:

- **Funding:**

- The majority of Case Management services are provided solely “within-program,” based upon category, program-eligibility, or funding limitations.
 - Medicare, commercial insurances don’t reimburse for Case Management
 - Medicaid limitations on medical necessity, allegations of fraud, etc., limit provider willingness or availability to expand CCSS services
 - Medicaid restrictions on agencies who can provide CCSS (CSA, CMHC, FQHC, HIS) make more sense in a rural environment, where there are few providers, than in Albuquerque.
 - Unclear overlaps between case management, CCSS, care coordination, and MCO activities confuse clients and providers.
 - Hodge-podge nature of system of funding for Case Management leads to different rules, eligibility, access strategies, service provision strategies, client expectations and experiences, which can be bewildering to clients and citizens.
 - There is no statewide association of Case Managers, licensing or certification of case managers, no overarching umbrella over these various entities, services, etc., to ensure best practice, good care, or to facilitate information sharing and resource/referral development for case managers in different programs.
 - Peer support services are inconsistently and unclearly supported from a Statewide level, and from varied providers.
 - Redundant funding and services – many people interact with numerous case managers in different programs
 - Funding/legal limitations restrict use of many technologies such as social media, teleconferencing, etc.
- Clients who would benefit from Case Management to assist in accessing resources and benefits, often have difficulty obtaining case management, or even knowing that it exists;
 - Within Albuquerque, Case Management remains quite siloed between Mental Health and Substance Abuse divisions. I.e., the AMCI voucher is predominantly substance abuse services and case management focused on this. CCSS is predominantly focused on Mental health issues, with some limited co-occurring disorder attention.
 - Case managers all develop their own individualized resource lists, recognizing that these lists of services, contacts, processes, benefits, etc., are constantly evolving and changing.
 - Siloed system of services and funding hinders integration of medical and BH services/needs
 - The strength and successes of Case Management are rarely celebrated or acknowledged. These are folks in the trenches, whose work rarely gets identified or held up, though they usually have far more contact with individual clients, as opposed to therapists and psychiatrists. CM work often results in greater changes to basic needs, strengthening a person’s whole life.

Initial Recommendations:

- Needs-Based Provision of Case Management, rather than eligibility (funding stream) based system

- Development of City/County-wide, updated, monitored Resource/Guide list for services, benefits
- Use City 311 system to update resource guide, direct clients to it, and to Case Management resources
 - Could we support a phone number/resource system of its own? “424” = 4BH
- Could City/County funding of Case Management be used for Medicaid match, through partnership with HSD?
- Pursue/encourage greater support of Peer Support/Peer Specialist models of CCSS/Case Management
- Support integration of Case management services within Health Home/Patient Centered Medical Home model of integration with Physical and Behavioral Health.
- Delineate “levels” of Case Management services, distinguishing between short-term “quick and dirty” case management, versus longer-term case management/coordination needed to support stability.
- Work with HSD/CMS to investigate whether Case Management could be restored to Fee Schedule
- **Pie in the sky – Could an Albuquerque/Bernalillo County Waiver/Carve-out be possible, with blended funding? (similar to Milwaukee Wraparound)**
- **Pie in the sky – Are there technological innovations (Apps, texting, teleconferencing, social media) that could be utilized for Case management/coordination?**
- Clients networking with other clients to share resources using technology could be a great thing. Again, this could go through a 4BH (424)—(for Behavioral Health) number and web service.
- Also, a “for behavioral health” could be a repository for all health/social services and resources - behavioral issues are often interwoven with needing jobs, food, shelter, and other BH-related services. Breakdown could be Social Services, Jobs, Behavioral Health, etc.
- Could MCO’s add Case Management as a VAS?

We had our son go to a private psychologist from 16 - 18. She tested him and was not able to make a diagnosis but a list of issues. We thought that we had a "bad kid". We sent him to live with an uncle to get him away from his "friends" and finish high school out of state. While on a trip after graduation he had a manic attack where within a week he was in an outpatient psychiatric hospital in Sacramento, Ca. After an all day analysis with 3 doctors, he was diagnosed Bi-Polar. He now sees a private psychiatrist. The doctors and psychologists were not much help with finding family support. We researched online and found DBSA and NAMI. Both groups have bent over backwards to help with information and direction. We have been surprised at the lack of knowledge from the professionals on how to help the family, who helps direct services for the family member. The focus is on the patient who may not have the foresight that they need help. HIPAA is a disaster in terms of helping the patient. People with mental illness need help from family and friends to assist with medication and patient care. They do this in the dark once the patient turns 18.

I am the father of a 27 year-old son diagnosed with schizophrenia. Our son is unable to admit to needing or seeking help to make his life peaceful and meaningful, and is anxious about issues involved with initiating help. He has been living with us for almost a year, and we are at a loss as to effectively find needed resources, while our inquiries to help are hindered by the current system for patient protection and insurance issues. We ourselves are not clear on the actions it would take to get the help we need to help our son and our family to deal with his mental health. We are currently in the NAMI "Family to Family" program that has helped us to understand the disease and some of the resources available, and we have gotten some insight through contact with mental health resources and community meetings. I've made many calls to services, but can't seem to get a definitive path to begin help, especially since our son is protected under HIPAA, and unless we take more drastic measures than persuasion, he is resistant to seek help. Unless he is a direct threat to himself or others, our hands are tied to call law enforcement, which feels extreme, and I'm afraid may cause more harm than good. I feel that we need to categorize community services and develop a pathway to them. We also need to have a more robust non-crisis intervention resource to help families like mine that can work with families to get those that need help, be able to get it—difficult, but necessary. Our son has looked for help, but has been lost in the process. Develop one-stop shops; that allow easy application for Medicaid, and easy entrance to the system—keep it consistent and advertise it with flyers, banners, and the web.