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A NATIONAL SURVEY OF MEDICAID CASE-MANAGEMENT PROGRAMS

by Bruce Spitz

Prologue: The proliferation of federal grant programs over the last fifty years has sought to address a wide variety of social ills faced by people in difficult circumstances. Within this framework, federal health programs have been designed to deal with medically related problems. While significant progress was achieved through this process in ameliorating some of the rougher edges of capitalism, an unwieldy program structure was also created that essentially addressed peoples larger problems as categorical fragments rather than pieces of a larger whole. Out of this circumstance, and of continuing demands for government to achieve greater value for the limited tax dollars it invested in dealing with social problems, the concept of case management emerged. In this overview of the concept as it has been applied in the Medicaid program, Bruce Spitz outlines some of its pitfalls in a national survey of case-management programs. Spitz is not an enemy of the concept—he believes it makes a lot of sense—but he fears that people are so enamored of it that they have failed to grapple with its many definitional and implementational challenges. He is director of the Pew Foundation's Associates Program at the Health Policy Center of Brandeis University's Florence Heller Graduate School. The program's goal is to provide technical assistance to corporate and public purchasers of health care in selected American cities. For a number of years, Spitz has been centrally involved in helping many states improve their Medicaid programs through the development of more refined payment systems for hospitals, nursing homes, and health maintenance organizations. He also has worked with the National Governors' Association, the Health Care Financing Administration, and the National Center for Health Services Research on the case-management delivery concept.
Case management has become a central component of Medicaid innovations of the 1980s. It has been used by almost every state to improve the way in which care is provided to Medicaid clients in general (in Michigan, Kansas, and Colorado). And it has been used for clients with special conditions or needs, such as very costly patients whose use of care is medically unwarranted (in Illinois), pregnant mothers who are at risk of having low-weight babies in need of neonatal care (in South Carolina), individuals who have already suffered catastrophic illnesses or accidents (in Indiana), and the frail and elderly in need of community-based services (in New York). Despite its common presence in Medicaid programs, case management remains a slippery term and an elusive process. The confusion surrounding case management is a product of its interdisciplinary application, its evolving functional definitions, and its association with alternative delivery systems and capitation.

The Evolution Of Case Management

Case management is applied in many disciplines, primarily social work, mental health, geriatrics, primary care, and trauma medicine. Professional discussions of case management date back at least to the late 1920s. However, the term “case management” was not introduced into the federal government until the 1960s a period of rapid growth in health and human services. During the Kennedy and Johnson administrations, much of this expansion occurred as a multitude of narrowly defined categorical grants. While these new programs may have greatly increased the availability of services, they did not necessarily increase access to those services. In particular, individuals with complex problems needed assistance to overcome bureaucratic barriers erected by a “network of services that [were] . . . fragmented, duplicative, and uncoordinated.” This assistance was case management. It was a mechanism that would employ someone who understood federal programs and the specific needs of a particular client. This bureaucratic guide would then coordinate programs to increase a client’s access to public programs.

Case management formally made the leap from the Executive branch to Congress during the Nixon administration under the guise of the Allied Service Act of 1972. This resolution was supported by Elliot Richardson, Secretary of the Department of Health, Education, and Welfare (DHEW), and sponsored by Representative Roy Perkins. It proposed a consolidation of social services programs to provide a full range of services and increase access to care. The resolution never passed but the idea persisted, and reemerged in the Community Mental Health Centers legislation of 1975 (P.L. 94-63).

Several themes persisted during this period. Case management was frequently viewed as a community support program, which relied on an...
interdisciplinary team (of medical and nonmedical professionals) that coordinated benefits and maximized the client's access to care.

By the 1980s a permutation of case management had developed in response to federal budgetary problems. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, case management was transformed from a process that increased access to a process that increased efficiency. Under this legislation, state Medicaid programs could receive federal waivers that allowed them to “implement a case management system . . . which restricts the provider from or through whom a recipient can obtain primary care.” Federal requirements prohibited case management from “substantially impair[ing] access to services of adequate quality” and mandated “that a specific person or agency be responsible for locating, coordinating, or monitoring Medicaid services on behalf of a recipient.” In addition, states would have to demonstrate that case management was “cost-effective.”

Cost-effectiveness and efficiency, OBRA’s underlying themes, became the basic measures of performance for case management in all of its legislative forms (for primary care, home- or community-based waivers, and the lock-in provisions for recipients who overutilize Medicaid services). Case management had become a vehicle for living with less. This current version relies on a case manager, generally a physician, who provides, supervises, and approves all the medical care provided to a client. The client, in turn, must receive care from or through the case manager. This approach to case management increases access to a point of care (the case manager) while reducing generalized access to care (that is, to other providers through self-referrals by the patient).

Two models of case management have evolved. The first relies on an interdisciplinary team coordinating services to improve a client’s access to medical and nonmedical services. The other model depends upon a physician case manager who provides and approves all of the medical care that a patient receives and who strives to be cost-effective. In some instances, of course, a hybrid of both models has been used.

Another confounding aspect of case management is that it has become linked to alternative delivery systems, There is an implicit connection to capitated systems (such as health maintenance organizations, or HMOs, and primary care networks) that must survive on a fixed budget and physician case managers who are supposed to maximize the impact and effectiveness of those limited resources. Indeed, it is the case managers who act as critical safeguards in capitated systems and allegedly work toward maximizing patients’ access to needed and appropriate care. Despite this connection to capitation, the most popular version of case management is a program developed in Michigan, the Primary Physician Sponsor Plan (PPSP), which is grafted directly onto the fee-for-service system. In this program, primary physicians receive three dollars a
month for each enrolled patient but are reimbursed for all services they provide on a fee-for-service basis and are not financially at risk for any other services that their patients might use. Since its inception in 1982, the PPSP program has been emulated in part or entirely by five states and represents more than half of the case-management enrollees.

All of this, then, lends to the difficulty most people have when discussing case management because one term triggers different professional, functional, and financial connotations. It was this problem of multiple meanings that prompted our interest in conducting a national survey of Medicaid case management programs.

Two other developments, however, make this survey both interesting and disturbing. First, in 1981 there was not a single Medicaid case-management program operating. By 1986, nineteen states had more than 651,000 individuals enrolled in programs they described as case management. Although case-management enrollees account for only 3 percent of the total number of Medicaid eligibles, this growth has been much more rapid than the Medicaid experience with another major innovation in the delivery of health care: HMOs. For example, HMO enrollment in Medicaid hovered between 1 and 2 percent of the eligible population for most of the 1970s, and increased to 4 percent by 1985. The relative rates of growth suggest that case-management programs may surpass HMOs in enrollment in the near future. It also indicates that case-management programs may possess greater applicability and ease of implementation than do other major Medicaid innovations.

The second point of interest was the legitimacy that Congress lent to case management. Congress considered the OBRA-initiated case-management experiments so successful that, in 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) allowed states to provide case management as an optional Medicaid service without seeking a federal waiver. There was a major hitch to this new benefit. It is defined so broadly that for all practical purposes it remains undefined. The legislation describes case management as helping recipients “gain access to needed medical, social, educational, and other services.” States, however, are unable to determine what this means. According to a fifty state survey of Medicaid directors performed by the National Governors’ Association, administrators were uncertain about what was being offered: “Case management lacks a precise conceptual or operational definition. In the absence of a definition, case management typically describes a range of activities that can vary from routine, minimally professional referral services, to primary nursing, to comprehensive care plan development, oversight, and monitoring.”

As might be expected, this ambiguity has created some uneasiness among state administrators. The lack of federal precision could keep any state that offers an optional but specific case-management service perma-
nently in court, fending off suits by every excluded professional group claiming equal right to state payments for their particular brand of case management. The states’ problem with case management, however, also reflects genuine confusion about the term and the process. So we have come full circle: an ill-defined process has spawned a large number of state programs, which has led to federal institutionalization of the process, which states are reluctant to implement because it is ill defined.

**National Survey Results**

In the fall of 1986, the Health Policy Center of Brandeis University, in conjunction with the Intergovernmental Health Policy Center of George Washington University, conducted a national survey of Medicaid agencies to discover whether the definitional; procedural, and policy questions raised about case management were being resolved in the implementation of these programs. We had relatively simple criteria for examining a program: it had to be called case management by the state, it had to be primarily medical in nature, and there had to be state regulations governing the case-management process.

Because of the elusive nature of the case-management beast, these selection criteria inevitably omitted programs either because of labeling problems (for example, Florida’s Rural Efforts To Assist Children At Home–REACH), or because the emphasis was not medical (for example, the home and community-based waivers), or because state regulations do not exist (for example, a voluntary high-cost case-management program in Indiana is administered by the statewide health-insuring organization, or HIO–Blue Cross of Indiana–with the state’s approval but with regulations internal to Blue Cross). The selection criteria also introduced a strong bias. Nearly all of the programs reviewed were the provision and supervision model. This may be a product of emphasizing the medical aspects of case management, although that is not a necessary outcome. For example, high-cost case management tends to be a medical program that stresses coordination of resources.

**Characteristics of case management.** While the selection problems have inevitably led to omissions and preclude us from claiming that the survey is all-inclusive, they nonetheless do not prevent us from beginning to describe the operational characteristics of case management. As of December 1986, nineteen states had enrolled 655,138 individuals in case-management programs (Exhibit 1). The largest program was Kentucky’s statewide KenPAC, with 204,000 clients; the smallest was in South Carolina, with only 300 clients. Most of the programs had been operating for less than two years and were distributed fairly evenly throughout the country. All but four programs required that a specific physician act as the case manager for each enrolled client. In most states, that physician...
case manager was responsible for providing or approving all physician, inpatient, and outpatient hospital services, and for providing twenty-four-hour coverage. Patients were required to receive prior approval from their physicians for covered services.

The case-management programs tended to have broad applicability. They were available to larger geographic areas and a wider variety of clients than were HMOs. For example, twenty-one states have contracts with HMOs, but more than 70 percent of all Medicaid HMO enrollees in the nation are in six metropolitan areas: Los Angeles, Phoenix, Madison, Milwaukee, Detroit, and Chicago. While case-management programs exist in fewer states than do HMOs with Medicaid contracts, participation in each state was much broader than that found with HMOs. Five of the case-management programs were statewide (as opposed to being restricted to specific counties or cities). HMOs also tend to restrict their enrollment to Aid to Families with Dependent Children (AFDC) clients,

### Exhibit 1
**Medicaid Case Management Enrollment As Of November 1986**

<table>
<thead>
<tr>
<th>States</th>
<th>Date program began operation</th>
<th>Current number of enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCCM</td>
<td>8/1984</td>
<td>68,660</td>
</tr>
<tr>
<td>Redwood</td>
<td>10/82</td>
<td>5,160</td>
</tr>
<tr>
<td>Santa Barbara</td>
<td>9/83</td>
<td>43,000</td>
</tr>
<tr>
<td>Colorado</td>
<td>5/83</td>
<td>20,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>67,000</td>
</tr>
<tr>
<td>Connecticut</td>
<td>6/86</td>
<td>1,000</td>
</tr>
<tr>
<td>Kansas</td>
<td>2/84</td>
<td>40,726</td>
</tr>
<tr>
<td>Kentucky</td>
<td>2/86</td>
<td>204,000</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>7/82</td>
<td>6,489</td>
</tr>
<tr>
<td>Michigan</td>
<td></td>
<td>85,352</td>
</tr>
<tr>
<td>PPSP</td>
<td>7/82</td>
<td>82,000</td>
</tr>
<tr>
<td>CAP</td>
<td>83</td>
<td>3,352</td>
</tr>
<tr>
<td>Minnesota</td>
<td>12/85</td>
<td>16,708</td>
</tr>
<tr>
<td>Missouri</td>
<td>1/84</td>
<td>3,649</td>
</tr>
<tr>
<td>Nevada</td>
<td>11/83</td>
<td>2,564</td>
</tr>
<tr>
<td>New Jersey</td>
<td>7/83</td>
<td>5,103</td>
</tr>
<tr>
<td>New York</td>
<td>2/87</td>
<td>2,500</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2/86</td>
<td>1,700</td>
</tr>
<tr>
<td>Oregon</td>
<td>5/85</td>
<td>16,170</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>3/86</td>
<td>92,377</td>
</tr>
<tr>
<td>South Carolina (HRCP)</td>
<td>4/86</td>
<td>300</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2/84</td>
<td>8,400</td>
</tr>
<tr>
<td>Utah</td>
<td>7/82</td>
<td>30,500</td>
</tr>
<tr>
<td>Washington</td>
<td>1/86</td>
<td>5,400</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>655,138</td>
</tr>
</tbody>
</table>
whereas in nine of the case-management programs, enrollment was open to SSI (Supplemental Security Income for the elderly, blind, and disabled) and AFDC clients. Institutionalized individuals, however, tended to be excluded from case-management programs. Thus, those individuals who might benefit the most from improved supervision or coordination of care cannot be enrolled in these programs.

**Mandatory or voluntary programs?** Twelve of the states had mandatory programs; that is, recipients and providers had to participate if they were either to receive Medicaid benefits or to be paid for services. Six states were voluntary, and one state—California—had both voluntary and mandatory programs in different regions of the state.

The case-management programs point out how nondescriptive the mandatory/voluntary designation is. Mandatory carries with it a notion of restricted choices and unpalatable solutions, ones that could only be implemented with force. In many of the mandatory states, however, the clients' choices were actually enhanced. They often received information about providers that was not normally available. For example, in some states, when clients were asked to choose a case manager, they would not only be given the names, locations, and specialties of physicians, but were also told whether the physicians were accepting patients and the languages spoken in the physicians' offices. Clients were also given a guarantee that they never received under fee-for-service—for the first time, states assumed the responsibility for assuring their clients access to primary care physicians. The mandatory programs also paid explicit attention to client satisfaction. Indeed, patients in a “mandatory lock-in” often had much easier recourse to registering a complaint and finding a new physician than did their counterparts in fee-for-service.

The restrictive aspects of these programs did not appear overly burdensome. While clients must choose or be assigned to a physician, none of the mandatory programs prevented patients or their physicians from breaking their relationship. Two states did not provide any reasons that would justify a physician's terminating the relationship but did allow patients to change physicians either on request or because the patient/physician relationship failed. In either case, physicians could play the lead role in helping patients make the desired choice. It should be noted that even though patients were not irrevocably locked in to any physician, case management did impose procedural requirements that must be adhered to if patients changed providers. Even if these requirements were minimal, they slowed down the rate at which patients could move from primary care physician to primary care physician.

Thus, mandatory case management seems to mean that patients must choose a provider or “risk” being assigned to a case manager. It means that clients will always have a guaranteed point of access into the system and an increased likelihood that “continuity of care” will be enhanced.
Finally, it means that, regardless of whom clients pick or how many times they change their case manager, their general access to any specialist, clinic, or hospital will be restricted or eliminated. This last attribute may be the biggest drawback to a mandatory program, but again it is not inconsistent with developments in the fee-for-service sector.

The role of physicians. Under case-management programs, primary physicians’ control over their patients is increased vis-a-vis their traditional fee-for-service role. Not only did all states require that case managers approve all covered elective services, but nine states required prior approval for emergencies and seven of those states—which we will refer to as high-risk states—had programs that placed primary care physicians at full or partial financial risk for their patients. It is possible in these high-risk states that physicians will face a financial and medical conflict when their patients are in life-threatening conditions.

It would be reasonable to assume, then, that states would impose some additional conditions for participation on physician case managers. In fact, most states maintained their fee-for-service standard of requiring only a medical license. Of the nineteen states involved, only six (two of the high-risk states) required that case managers have admitting privileges at participating hospitals. Only two states, both high risk, required that physicians carry medical malpractice insurance. Only five states (three of them high risk) excluded physicians who had ever been suspended or had their Medicaid participatory status revoked. In four high-risk states, the absence of this restriction allowed physicians with a proven record of illegally exploiting the fee-for-service system to practice their wares under capitated arrangements. Finally, and this ranks among the more bizarre omissions, only one state required that physicians have access to and admitting privileges at long-term care facilities despite the fact that nine states enrolled elderly and disabled clients into case-management programs. It may be that these admitting privileges are granted easily and therefore are not a necessary requirement. This would be a problem only for those clients who happen to be assigned to one of the few physicians denied direct access to nursing homes in a specific area.

Clinical protocol. Most programs clearly set forth the new boundaries of performance: patient assignment, physician prior approval, and twenty-four-hour coverage. But what of the clinical substance of case management? What did the state expect physicians to do differently now that they were case managers as opposed to being family practitioners or internists or cardiologists? For example, were case managers supposed to provide a different or more comprehensive array of preventive services? Were episodic and acute cases to be handled differently? Were there standard protocols for frequently encountered medical conditions? When and how was the use of specialists and other referrals to be handled? What kinds of outcomes were expected for patients with
specific conditions? In short, were there any clinical standards or expecta-
tions that differed from the states’ treatment of fee-for-service physi-
cians? On this issue, the states were for the most part silent. Nine of the
states had programs in which there was no clinical protocol. Two states
made the Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
protocol, which is designed for children and offered under fee-for-
service, an optional requirement for case managers. These eleven states
have opted for a rather puzzling position, since EPSDT is the closest
thing to clinical protocol for case management in Medicaid. Nine states
required that EPSDT protocol be followed by case managers. However,
these standards existed in the fee-for-service program. They did not
provide any guidance to physicians concerning the clinical substance of
their new positions as case managers.

Only three states—Massachusetts, New Jersey, and South Carolina—
extended their clinical requirements beyond EPSDT In the remaining
seventeen states, more than 643,000 individuals were enrolled in case-
management programs in which case managers were unable to discern
how they were supposed to change their clinical behavior. Certainly, if
physicians are unable to know when their behavior as case managers is
clinically appropriate, the state is unable to determine when case man-
agement occurs and when it does not.

Conclusions

Our search for understanding case management by examining its
administrative reality brings us to a disturbing conclusion. In concept
and in practice, case management appears to be an ill-defined process
that lacks substance. If case management programs are “cost-effective,”
we would argue that it is only because these programs reduce generalized
access to care or because physicians selectively enroll healthy or disenroll
sick patients. If these programs are easy to implement, it may be because
they change very little other than the care-seeking behavior of the
patients. Something else may be happening in these programs. There
may be, in fact, a clinical improvement in the type of care that patients
are receiving. In most of these programs, however, there is nothing that
necessitates that outcome in either the kinds of providers that are
permitted to participate or the expectations that are imposed upon
them.

Operational limitations are neither a condemnation of a concept nor a
permanent condition. It is reasonable to assume that as these programs
mature, medical protocol will be adopted and a clearer understanding of
case management will evolve. Indeed, this appears to be happening in
states such as Minnesota and Pennsylvania where an extensive and
specific array of standards are being developed. In the meantime, the
biggest danger the public and private sectors face is the rhetoric of case management, the promise of magic, and the lure of something that seems slippery and elusive because it is slippery and elusive.

NOTES


7. Social Security Act, Title XIX, Sec. 431.55(b)(l); Social Security Act, Title XIX, Sec. 431.55(c)(l), (2).


10. Consolidated Omnibus Budget Reconciliation Act of 1985, Sec. 9408(g)(2).


