

*REDESIGNING*  
*CASE MANAGEMENT SERVICES*  
*FOR PEOPLE WITH DISABILITIES*  
*IN MINNESOTA*

A Report to the Legislature  
And Minnesota Department of Human Services

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## EXECUTIVE SUMMARY

In February 2006, the Minnesota Department of Human Services (DHS) requested proposals to assist the Department in addressing Laws of Minnesota 2005, First Special Session, Chapter 4, Article 7, Section 59 that required a report to the Legislature on the redesign of case management services. The areas to be addressed were:

- (1) streamlining administration;
- (2) improving access to case management services;
- (3) addressing the use of a Comprehensive (universal) Assessment protocol for persons seeking community support;
- (4) establishing case management performance measures;
- (5) providing for consumer choice of the case management service vendor; and
- (6) providing a method of payment for case management services that is cost-effective.

### A. RECOMMENDATIONS

The Institute on Community Integration at the University of Minnesota prepared this report on proposed models for reforming case management. Based on significant stakeholder input, review of state and national reports, and interviews regarding innovative models across the country, our six major recommendations are:

#### 1. Standardize and Simplify Case Management Processes

- A. Minnesota should continue to standardize and simplify processes such as the Comprehensive Assessment, service plan format, and a common menu of service options.

Since the April 2005 report to the Legislature on case management, work on the Comprehensive Assessment process and common menu of service options has progressed very well. These projects and other efforts to standardize and simplify processes should be continued and expanded.

- B. Minnesota should invest in a coordinated, streamlined management information system for support technology.

A comprehensive information system in which information flows from intake to assessment to planning to monitoring to incident reporting to quality assurance, which is linked to other needed database systems, could greatly improve access and ongoing service coordination across all disability groups. In addition, it could also greatly enhance determination that performance measures are being met. If duplication can be reduced, case management and case aide time devoted to consumers can be increased. With such an information system, inequities between groups, individuals, and counties can be reduced.

- C. Minnesota should improve and expand information and referral supports for individuals with disabilities.

D. Minnesota should continue to improve business practices for case management.

**COSTS:**

Most of these initiatives are already being addressed. For the comprehensive management information system recommended in B, other states have invested \$20 million to \$50 million in such systems and report improved performance, reduced errors, improved tracking concerning fulfillment of minimum requirements and more uniform enforcement of policies. These systems can be adapted for use in Minnesota for an estimated \$2 to \$3 million for the system itself; additional costs will be involved in implementing the system for use by all counties.

**2. Maximize Individualization while Assuring Minimum Performance Standards**

Performance standards (e.g., timelines for assessment and planning) across the different funding streams should be standardized. The coordinated management information system proposed in Recommendation #1.B. above can greatly improve performance. Certain performance measures should also be adapted to use individually determined schedules or standards as the performance measure for monitoring.

**COSTS:**

First, an optimal implementation structure for monitoring performance could be established through the management information system discussed above in Recommendation #1.B. Second, the meeting of performance measures is also critically tied to caseload size, discussed in Recommendation #6 below.

Third, in light of the linchpin role that case management plays in supporting people with disabilities in the community, Minnesota should make a continuing investment in case management technical assistance and performance improvement. It is recommended that an amount equal to one percent of total annual case management expenditures be earmarked for this purpose (i.e., approximately \$750,000). These funds would be available to DHS to furnish technical assistance and to engage in system-wide quality improvement projects.

**3. Increase Opportunities for Consumer Choice of Case Manager**

Counties should maintain administration, gatekeeping and quality assurance functions of case management, and options for consumer choice of service coordination functions should be increased. Expanding consumer choice will require increasing the number of and consumer access to private case management agencies, designing structures to assure meaningful choice, assuring that private case management is free of conflict of interest, and assuring reimbursement for both county and private agency functions.

Two phases are recommended. In the first phase, counties would retain responsibility for gatekeeping, administration and quality assurance while increasing their contracted use of private vendors for service coordination. The first phase would also include developing opportunities for meaningful consumer choice among case managers. In the second phase, the state would

allow open enrollment of private vendors (direct contracts with the state) for service coordination functions, further increasing options for consumer choice.

**COSTS:**

While an increase in ongoing service coordination by private case managers will likely reduce per-person case management costs, there are significant costs for the county in training and monitoring of private providers. Most counties already contract with private agencies, and systems are already in place for private contractors to bill the state. Hence, it is anticipated that overall costs will be neutral. In the long-term, per-person case management costs are likely to decrease. Proposals for shifting the funding sources for both county and private case management are addressed in Recommendation #5 below.

**4. Regionalize Some County Administrative Functions**

Regionalizing some county administrative functions that affect case management is likely to result in overall cost savings, streamlining processes, and assisting counties in addressing some current challenges. Functions that could initially be regionalized include contracting, licensing of providers, management of waiver slot allocations, and quality assurance.

**COSTS:**

The state should encourage regionalization by inviting counties to propose how they would consolidate operations, and by providing funding to support the development of consolidation plans and to cover one-time regionalization costs. It is difficult to estimate the overall financial impact of regionalization of case management, since it would be dependent on factors such as size of each region, etc. Local county proposals could address estimates of costs and savings in a particular group of counties. As a starting proposition, it is recommended that \$500,000 be earmarked to support the development of consolidation plans and to be awarded to groups of counties through a Request for Proposal process.

**5. Simplify Medicaid Financing of Case Management**

The current case management financing system maximizes the capturing of federal dollars, but is cumbersome and complex. It can be simplified and capture as much federal financing by converting to a combination of administrative billing and targeted case management (TCM) reimbursement, which can also assist in expanding consumer choice of case manager. Current billing systems could continue to be used, but will need some modifications.

**COSTS:**

Consolidating Medicaid financing of case management under a TCM/administrative claiming architecture will require some changes in state and county Information Technology (IT) systems. Principally, these changes will impact administrative claiming with respect to ensuring that the full range of claimable administrative costs are identified and properly attributed to Medicaid. This likely will require modifying the Social Service Time Study (SSTS) and its algorithms for attributing time to federal programs, and include the identification of county administrative costs associated with case management but which are not captured in present systems. If the state

commits to pursuing this option, further analysis would be required to develop an estimate of these costs, including the cost of training.

## **6. Standardize Caseload Sizes**

There is a wide degree of variation in caseload size from county to county, with a range of 20 to 100 persons on caseloads. For amount of service provided, units billed annually per consumer range from 30 to 168. Just in services for persons with mental retardation and related conditions (MR/RC), Minnesota's average caseload size of 52.8 is higher than the national average of 40; only eleven (generally smaller) counties are at or below the national average.

Many of Minnesota's larger counties have caseloads that are well above the nation-wide norm. The relatively high case loads that case managers are carrying explains why they spend a large proportion of their time dealing with crisis cases. In order for case managers to devote more time to individuals, their present caseloads need to be reduced.

Standardizing caseload size assures that consumers have access to at least a baseline level of case management support county-to-county. A caseload standard can serve as a useful benchmark in addressing the adequacy of case management funding and the efficiency of case management delivery, and also serve as a basis for determining an appropriate payment rate for case management.

### **COSTS:**

Implementing a 1:40 caseload standard across all four waivers would have a total federal/state Medicaid cost of \$16.3 million and require an additional \$8.2 million in state matching funds, based on the number of waiver participants in 2005. Additional expenditures would be required if that same ratio were applied to persons receiving case management under Vulnerable Adults and Adults with Developmental Disabilities Targeted Case Management (VA/DD-TCM).

## **B. PROJECT ACTIVITIES**

This study investigated case management practices and models that are currently being used by Minnesota counties supporting persons under age 65 with physical, cognitive, and complex medical needs.

The study was aimed at the following groups:

1. People with developmental disabilities meeting the definition of persons with mental retardation or related conditions;
2. People using personal care assistance (PCA) services who are under the age of 65;
3. People using home care services under the age of 65 who have a disability determination.
4. People with traumatic or acquired brain injury;
5. People with physical disabilities or chronic medical condition(s), under the age of 65 who have a disability determination;
6. People in nursing facilities (NF) who are under the age of 65; and

7. People on any of the four disability waivers that are not already mentioned above (Community Alternative Care, Community Alternatives for Disabled Individuals, Traumatic Brain Injury and Mental Retardation/Related Conditions).

There were two recent previous reports to the Legislature on the redesign of case management in Minnesota, in February 2003 and April 2005. These reports identified the challenges of:

- Increased choices creating a demand on resources
- Tensions created by limits on services
- Duplication and redundancy
- Overlapping eligibility for programs
- Variation of rules, standards and reimbursement from program-to-program
- Inequities from group to group
- Multiple assessment processes
- Variation in quality from county to county and case manager to case manager

For this report, the Institute on Community Integration was specifically requested to study innovative models in other states and local areas to address case management and funding options. Most states are faced with a situation of declining resources in the face of expanding demand. There are current strong federal pressures to limit or decrease case management expenditures while improving quality and expanding consumer choice.

The recommendations contained in this report came from several sources, including reports from Minnesota and other states, federal and national reports, information from national and international experts, input from various Minnesota stakeholder groups, and interviews of representatives from other states which were recommended for their innovative models.

Input from Minnesota stakeholders was obtained from interviews with representatives in 19 Minnesota counties and a series of stakeholder focus group meetings in 4 geographic areas in September 2006, attended by 277 people, and November 2006, attended by 172 people. There was strong agreement among the various stakeholder groups on which areas of the system need improvement.

## **C. FINDINGS**

Strengths of Minnesota's case management system include strong local working relationships and teams, the independence of the county case management role from service-providing roles, and the extent to which Minnesota maximizes federal financial participation for funding case management services. Weaknesses include a cumbersome and conflicting administrative and funding structure, with inequities between disability groups, counties, and the numerous funding streams.

National disability experts recommended innovative case management models in other states, and information was collected from twenty other states. Minnesota lags behind some states that have developed innovative data based management information systems to coordinate information and services, and also behind some states that have better-established structures for

self-determination and consumer choice. Minnesota is currently similar to several other states in making efforts to streamline and simplify processes across the various disability groups and to maximize services and support in the face of diminishing resources.

#### **D. PHASE-IN STRATEGIES**

As these reforms are implemented, Minnesota should support significant involvement of various stakeholder workgroups to refine specific implementation procedures.

Any reform efforts in Minnesota should:

- Streamline case management administration
- Improve access and service availability
- Assure basic safeguards
- Improve accountability and performance
- Promote consumer choice and self-determination
- Honor individualization

Besides the six major recommendations above, other supplementary recommendations to improve case management and system performance and efficiency are included in this report.

Each of the recommendations of simplifying Medicaid financing, regionalizing functions, increasing private case management for service coordination and equalizing performance standards will have a fiscal impact. The impact of each of these reform efforts will need to be monitored and managed. Significant system and case management effectiveness and improvement in performance are intrinsically tied to size of caseloads, adequacy of management information systems, and consumer choice of case manager.



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# REDESIGNING CASE MANAGEMENT SERVICES IN MINNESOTA

## I. SUMMARY OF PROJECT RECOMMENDATIONS

In February 2006, the Minnesota Department of Human Services (DHS) requested proposals to assist the Department in addressing Laws of Minnesota 2005, First Special Session, Chapter 4, Article 7, Section 59 that required a report to the Legislature on the redesign of case management services. The areas to be addressed were:

- (1) streamlining administration;
- (2) improving access to case management services;
- (3) addressing the use of a comprehensive universal assessment protocol for persons seeking community support;
- (4) establishing case management performance measures;
- (5) providing for consumer choice of the case management service vendor; and
- (6) providing a method of payment for case management services that is cost-effective.

There are six principal areas of recommendation in this report. They are summarized briefly here, and a more detailed explanation follows in Section VIII.

### **1. Systems Coordination – Standardize and Simplify Processes**

As indicated in the April 2005 report to the Legislature on case management for persons with disabilities, there is a need to standardize general practices, protocols, methods of reimbursement and performance outcomes in order to improve equity for and satisfaction of consumers, and to create a more efficient system of coordinating services.

Since the April 2005 report, there has been progress on several recommendations in this area, including other projects which have addressed the Comprehensive (Universal) Assessment protocol. Two other projects are also in process, one on a Common Service Menu and the other is the Quality System Architecture project on equity and quality in these processes.

This report contains additional recommendations, including a strong recommendation for a unified database. A comprehensive information system in which information flows from intake to assessment to planning to monitoring to incident reporting to quality assurance, which is linked to other needed data-base systems, could greatly improve access and on-going service coordination across all disability groups. If duplication can be reduced, case management and case aide time devoted to consumers can be increased. With such an information system, inequities between groups, individuals, and counties can be reduced.

### **COSTS:**

Other states have developed award-winning comprehensive databases for \$20 million to \$50 million. These databases have been able to be adapted by other states for \$2 million to \$3 million.

## **2. Increase and Maximize Individualization While Assuring Minimum Standards**

Performance standards (e.g., timelines for assessment and planning) across the different funding streams should be standardized. The coordinated management information system proposed in Recommendation #1.B. above can greatly improve performance. Certain performance measures should also be adapted to use individually determined schedules or standards as the performance measure for monitoring.

There are many instances of redundancy and duplication, in which case managers are spending their time and resources on fulfilling requirements because of regulations rather than consumer need. Some elements of the system imply a “one size fits all” model of providing case management. Individualization for each consumer and family should be able to be maximized, while some minimum standards are in place to assure basic protection and over-sight.

Options and flexibility should be maximized to allow creative, person-centered, and individualized options so that each person gets what he/she prefers and needs. The number and type of rules should be either reduced or varied to allow more creative responses to individuals’ unique circumstances. Recommendations in this area include:

- A. Standardize performance measures across disability groups and funding streams; and
- B. Expand individualization of performance measures.

### **COSTS:**

First, an optimal implementation structure for monitoring performance could be established through the management information system discussed above in Recommendation #1.B. Second, the meeting of performance measures is critically tied to caseload size, discussed in Recommendation #6 below.

Third, in light of the linchpin role that case management plays in supporting people with disabilities in the community, Minnesota should make a continuing investment in case management technical assistance and performance improvement. It is recommended that an amount equal to one percent of total annual case management expenditures be earmarked for this purpose (i.e., approximately \$750,000). These funds would be available to DHS to furnish technical assistance and to engage in system-wide quality improvement projects.

## **3. Increase Opportunities for Consumer Choice of Case Manager**

Federal review of Minnesota waiver applications is likely to continue to stress that consumers should have a choice of case manager and not be limited to counties as the sole source. In addition, consumer, advocate, and provider stakeholders in this project rated increasing choice of case manager as highly important. We are recommending a structure in which gatekeeping, administrative and quality assurance roles would remain with county social services. The number of private case management agencies would be increased to fulfill the ongoing service coordination role, and the opportunity for meaningful choice by consumers would need to be addressed. A model used in Dane County, Wisconsin, which provides consumers the

opportunity for meaningful choice among potential case managers, is recommended as an option to review and adapt to Minnesota.

We are recommending a two-phase process. In the first phase, counties would increase the number of private agencies with which they contract for service coordination. This phase would include structures for assuring meaningful consumer choice among potential case managers. In the second phase, private case management agencies would be able to provide service coordination in an “open enrollment” process which would allow them to directly contract with the state for these functions. This process increases the opportunity for consumer choice. One option in this second phase is a three-party contract with the agency, county, and state.

**COSTS:**

While an increase in ongoing service coordination by private case managers will likely reduce per-person case management costs, there are significant costs for the county in training and monitoring of private providers. Most counties already contract with private agencies, and systems are already in place for private contractors to bill the state. Hence, it is anticipated that overall costs will be neutral, and per-person case management costs can decrease over time in the second phase. Proposals for shifting the funding of both county and private case management are addressed in Recommendation #5 below.

**4. Regionalize Some County Administrative Functions**

There is a great deal of redundancy and wasted resources because the basis for state operations in disability services is 84 contracts with 87 counties (a few counties have consolidated arrangements). Some county administrative functions which impact the delivery of case management could be regionalized to reduce waste and improve efficiency and service. These functions include: licensing, contracting, waiver allocations, and quality assurance.

The state could also consider regionalizing all disability services. From a business perspective, consolidation of case management operations among the counties would be likely to improve efficiency, especially with respect to gatekeeping functions and administrative overhead costs. Reducing the number of counties with which the state has to negotiate and do business for human services can simplify and reduce duplicative costs in administration and improve services.

**COSTS:**

The state should encourage regionalization by inviting counties to propose how they would consolidate operations, and by providing funding to support the development of consolidation plans and to cover one-time regionalization costs. While it is difficult to estimate the overall financial impact of regionalization of case management at this time, as a starting proposition, it is recommended that \$500,000 be earmarked to support the development of consolidation plans and to be awarded to groups of counties through a Request for Proposal (RFP) process.

## **5. Simplify Medicaid Financing of Case Management**

The ways in which case management for persons with disabilities is funded can be simplified and improved. In its 2005 report to the Legislature, DHS raised the potential of consolidating federal Medicaid funding through the targeted case management (TCM) option for the service coordination elements of case management with counties retaining gatekeeping and other management responsibilities. We recommend that Minnesota adopt this framework with an end goal of shifting to open enrollment of qualified service coordination providers under TCM. This change should be implemented in two stages (also referenced in Recommendation #3 above).

The first stage will entail crafting TCM coverages to replace the current CAC, CADI, TBI and MR/RC Waiver coverages. Crafting these coverages will provide Minnesota the opportunity to ensure consistency in the scope of required/allowable service coordination activities furnished on behalf of people with disabilities. Concurrently, other modifications will be necessary to support the claiming of Medicaid administrative funding for county gatekeeping functions, including functions related to county oversight of non-county service coordination providers. The current structure wherein counties serve as the primary providers of case management would be retained and counties would continue to contract with non-county providers as is presently the case. In this phase, counties would be encouraged to increase their use of non-county providers. Such a change will require time to accomplish, since current state and local accounting and billing systems can be used, but will need some modifications.

In the second stage, Minnesota would implement open enrollment of service coordination providers. Again, counties would retain gatekeeping and other management responsibilities. The state could contract directly with case management provider agencies, or there could be a three-party contract including the county. Individuals and families would be able to freely select from among all qualified service coordination providers, including county service coordinators. This stage would continue to entail the use of both TCM and administrative claiming.

These funding recommendations are more fully explained and compared with other financing alternatives in Section VIII below.

### **COSTS:**

Consolidating Medicaid financing of case management under a TCM/administrative claiming architecture will require some changes in state and county Information Technology systems. Principally, these changes will impact administrative claiming with respect to ensuring that the full range of claimable administrative costs are identified and properly attributed to Medicaid. This likely will require modifying Social Services Time Study (SSTS) and its algorithms for attributing time to federal programs, and include the identification of county administrative costs associated with case management but which are not captured in present systems. If the state commits to pursuing this option, further analysis would be required to develop an estimate of these costs, as well as training costs.

## **6. Standardize Caseload Sizes**

Standardizing caseload sizes but would be complex and costly, but this is a key recommendation for the delivery of case management with more efficiency, effectiveness, and equitability,

especially across counties. Currently, there is a wide degree of variation in caseload size from county to county, with a range of 20 to 100 persons on caseloads. For amount of service provided, units billed annually per consumer range from 30 to 168.

Just in services for persons with MR/RC, Minnesota's average caseload size of 52.8 is higher than the national average of 40; only eleven (generally smaller) counties are at or below the national average. Many of Minnesota's larger counties have caseloads that are well above the nation-wide norm. The relatively high case loads that case managers are carrying explains why they spend a large proportion of their time dealing with crisis cases. In order for case managers to devote more time to individuals, improve access, and ensure that case managers can meet performance measures, their present case loads need to be reduced.

Standardizing caseload size assures that consumers have access to at least a baseline level of case management support county-to-county. A caseload standard can serve as a useful benchmark in addressing the adequacy of case management funding and the efficiency of case management delivery, and also serve as a basis for determining an appropriate payment rate for case management.

#### **COSTS:**

Implementing a 1:40 caseload standard across all four waivers would have a total federal/state Medicaid cost of \$16.3 million and require an additional \$8.2 million in state matching funds, based on the number of waiver participants in 2005. Additional expenditures would be required if that same ratio were applied to persons receiving case management under Vulnerable Adults and Adults with Developmental Disabilities Targeted Case Management (VA/DD-TCM).

Each of these six primary recommendations is more fully explained in detail in Section VIII below. Supplementary recommendations are contained in Section IX.

## **II. PROJECT BACKGROUND**

In February, 2006, the Minnesota Department of Human Services requested proposals to assist the Department in addressing Laws of Minnesota 2005, First Special Session, Chapter 4, Article 7, Section 59 that required a report to the Legislature on the redesign of case management services. The Institute on Community Integration at the University of Minnesota responded to the Department's request for proposals to develop proposed models for reforming case management. The project period covered June 2006 through January 31, 2007.

This study investigated current case management practices and models used by Minnesota counties supporting persons under age 65 with physical, cognitive, and complex medical needs. Currently, Minnesota provides services to over 96,000 people with disabilities in its Medical Assistance Program, and other people with disabilities are served by a variety of non-Medical Assistance health and social service programs.

Two recent reports to the Legislature on the redesign of case management for Minnesotans with disabilities were submitted in February 2003 and April 2005. Since then, increased use of

contracted case managers, changes in the waiver approval processes by the Centers for Medicare & Medicaid Services (CMS), and anticipated reductions for TCM expenditures due to the Deficit Reduction Act have prompted the need for an updated analysis of case management practices and proposed reforms. The University of Minnesota's Institute on Community Integration was selected to evaluate current case management practices in Minnesota, to study innovative models in other states, and to recommend reform models for case management design and funding options. As part of this study, staff of the Human Services Research Institute of Oregon also provided funding and cost analysis.

This study focused specifically on the following groups:

1. People with developmental disabilities who have mental retardation or related conditions;
2. People younger than 65 years using personal care attendant services;
3. People younger than 65 years with a disability who use home care services;
4. People with traumatic or acquired brain injury;
5. People younger than 65 years with physical disabilities or chronic medical condition(s);
6. People younger than 65 years in Nursing Facilities (NF); and
7. People on any of the four disability waivers not already mentioned above.

The four waivers are:

1. Community Alternative Care (CAC) – home and community-based services funding for children and adults with chronic illness who would otherwise require hospital level of care.
2. Community Alternatives for Disabled Individuals (CADI) – funding for children and adults with disabilities who would otherwise require care in a nursing facility.
3. Traumatic Brain Injury (TBI) – funding for individuals with acquired or traumatic brain injury.
4. Mental Retardation/Related Conditions (MR/RC) – funding for children and adults with mental retardation or related conditions.

Proposals for reforming case management systems and practices must attend to the needs of both “ends” of the system. At one end are service recipients, the people with disabilities who require long-term support. Their needs include:

- a home, a job, friends;
- support to live their life in the least restrictive, most integrated environment; and
- a process of getting that support that provides them as much say as possible and that is as easy as possible.

At the other end are those responsible for funding and regulation. Their needs include knowing:

- that the system of funding and regulation is providing good stewardship of the available resources (that it is getting the most for its money); and
- that what it is buying reflects people's choices, is satisfying to the people who receive services, and meets at least a basic (minimum) standard of quality.



The county case management system is part of the interface between people who require long-term support because of their disabilities, and those who fund and regulate the system. That interface can be designed in many ways.

Challenges for Minnesota's current case management system design noted in previous reports to the Legislature include:

- Increased choices creating increased demands for scarce resources
- Tensions created by limits on services
- Duplication and redundancy
- Overlapping eligibility for programs
- Variation of rules, standards and reimbursement from program-to-program
- Inequities from group to group
- Multiple assessment processes
- Variation in quality from county to county and case manager to case manager

Many case managers and counties have done an excellent job based on the traditional ways in which their roles have been defined. However, recent and anticipated funding cuts, increasing caseloads with diminishing resources, and increased demand for self-determination and consumer direction are all forcing a redefinition of how case management functions are and will be fulfilled in Minnesota. Given the amount of funding supporting Minnesota's case management system, and the directive in this project to examine innovative models in other states, outcomes of the case management provided and any reform efforts undertaken should be expected to result in people with disabilities having better lives. In line with the legislative intent authorizing this study and best practices studied across the country, our recommendations are based on principles that any efforts to reform case management should:

- Streamline administration
- Improve access and service availability
- Assure basic safeguards
- Improve accountability and performance
- Promote consumer choice and self-determination
- Honor individualization

### **III. AN OVERVIEW OF CASE MANAGEMENT FINANCING IN MINNESOTA**

In Minnesota, case management for people with disabilities is furnished by counties or non-county providers that are under contract with the counties. When counties contract for case management, they retain ultimate responsibility for its provision. While case management is furnished to several distinct groups of individuals with disabilities, it is provided through a single, county-managed case management delivery platform.

Financing case management in Minnesota is complex. Minnesota accesses multiple federal (especially Medicaid) funding streams to pay for case management. The state and counties also

are part of the financing mix. More case management is funded through the Medicaid Waiver funding stream than any other source, followed by targeted case management and administrative cost recovery. In order to secure as much federal Medicaid funding for case management for people with disabilities as possible, these are the three distinct funding streams which Minnesota uses:

- 1. Home and Community Based Waiver.** Case management is a service covered by Minnesota under its Mental Retardation/Related Conditions (MR/RC), Traumatic Brain Injury (TBI), Community Alternatives for Disabled Individuals (CADI), and Community Alternative Care (CAC) Medicaid home and community-based services (HCBS) waivers. HCBS waiver case management is available only to the individuals who participate in these waivers. The federal statutory authority for covering case management under a HCBS waiver is located in §1915(c) of the Social Security Act. While the coverage of case management under each waiver is distinct, DHS has defined the scope of reimbursable case management activities in common terms across the waivers.

With respect to HCBS waiver case management, Minnesota pays counties a standard rate<sup>1</sup> for each 15-minutes of allowable case management activity performed by a county case manager on behalf of a specific waiver participant. That is, counties receive payment for HCBS waiver case management only to the extent that case managers document time and associated allowable activities on behalf of specific HCBS waiver participants. This Medicaid service claiming method of billing/documenting HCBS waiver case management activities is relatively common among the states. The state provides the necessary matching funds to draw down federal Medicaid financial participation for HCBS waiver case management. HCBS waiver case management county payment rates have not been re-based in several years and only periodically adjusted for inflation.

Funding for HCBS waiver case management is contained within the overall county allocation for waiver services. This means that spending for waiver case management competes with the purchase of other direct services on behalf of waiver participants.

- 2. Targeted Case Management.** Minnesota also covers case management under its Medicaid State plan for specified target populations. Under §1915(g) of the Social Security Act, a state may provide case management as a State plan benefit to a subset of Medicaid beneficiaries that the state defines or “targets” rather than providing case management to all Medicaid beneficiaries.<sup>2</sup> The scope of case management activities for which a state may claim federal Medicaid dollars under the TCM option is approximately the same as when case management is provided as a waiver service. Many states employ the TCM Medicaid coverage option in lieu of furnishing case management as a waiver service. TCM coverage also permits a state to provide case management not only to waiver participants but also other Medicaid beneficiaries who are members of the same target population.

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<sup>1</sup> There is one payment rate for the CADI, TBI, and CAC Waivers. There is a separate and somewhat lower payment rate for case management furnished to MR/RC Waiver participants.

<sup>2</sup> States have considerable latitude in defining a TCM target population. For example, a state may target adults with developmental disabilities who are eligible for Medicaid. Adult Medicaid beneficiaries who have other types of disabilities would not be eligible for targeted case management services. A state may fashion TCM coverages for several target populations.

In the case of people with disabilities, Minnesota has two relevant TCM coverages: (a) Relocation Service Coordination (RSC/TCM) to assist persons who reside in an institutional setting to return to the community and (b) Vulnerable Adults and People with Developmental Disabilities (VA-DD/TCM).<sup>3</sup> These TCM coverages permit the securing of federal Medicaid dollars for case management that is furnished to Medicaid eligible individuals who do not participate in an HCBS waiver and fall within the specified target populations. With respect to the VA-DD/TCM coverage, the counties rather than the state furnish the necessary matching funds to draw down federal Medicaid dollars. In essence, Minnesota passes federal Medicaid dollars through to the counties to help them offset their costs.

Payments for VA-DD/TCM services are structured differently than HCBS waiver payments. Counties are paid a monthly rate when they perform and record a TCM case management activity on behalf of an eligible person during a month. If an activity is not performed for a beneficiary during a month, the county may not bill for case management. This billing method differs from HCBS waiver case management – it is activity rather than time-based. This service claiming billing/payment method also is used by other states to pay for TCM services (and, in some cases, HCBS waiver case management). In addition, the monthly payment rate is figured on a county-by-county basis that reflects the county's level of effort in furnishing this type of case management. These county payment rates vary by county and are not standardized statewide.<sup>4</sup> When non-county contracted vendors furnish TCM, payment is made at the rate that the county has negotiated with the vendor. In contrast, RSC/TCM is paid on a standard statewide 15-minute unit rate.

- 3. Administrative Cost Recovery.** Through the operation of the SSTS system, Minnesota also recovers federal Medicaid dollars for county case management costs that are not directly attributable to a specific Medicaid beneficiary or billed as a service but qualify for federal payment. *Administrative claiming* covers assorted case-management related activities/costs that cannot be claimed as services. In the case of these costs, Minnesota also passes through the federal Medicaid dollars that are earned to counties. County funds underwrite the costs that are not federally reimbursed. Some states (e.g., Washington) exclusively employ administrative claiming to recoup federal Medicaid funds for case management activities performed on behalf of Medicaid beneficiaries.

Many of the complexities associated with the financing of case management in Minnesota arise from the use of multiple Medicaid funding streams to underwrite the county service delivery platform. Medicaid billing/claiming methods vary by funding stream. Also, there are differences with respect to whether the state or the county provides the matching funds necessary to secure federal Medicaid dollars. Minnesota has been very effective in securing federal Medicaid dollars to fund case management for people with disabilities. However, the price that is paid for securing these funds is administrative burden at the county and case manager levels.

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<sup>3</sup> Minnesota has a Medicaid State plan amendment pending before the federal Centers for Medicare & Medicaid Services to cover TCM for people who receive Home Care services but do not participate in an HCBS waiver. In addition, Minnesota has a long-standing TCM coverage for persons with mental illness.

<sup>4</sup> Prior year allowable costs for TCM are the basis of the rate. The higher a county's level of effort, the higher the county's rate and vice versa.

County case management expenditures that fall outside the federal Medicaid funding streams (e.g., case management that is provided to persons who are not eligible for Medicaid) are by and large (but not exclusively) a county's financial responsibility.<sup>5</sup>

In FY 2005, outlays for case management for people with disabilities totaled \$75.8 million as shown in the table below.<sup>6</sup>

Type of Case Management	Total Expenditure	Percent of Total Expenditure	Persons Served	Per Person Expenditure	Federal	State	County/ Other
CAC Waiver*	\$550,104	0.70%	240	\$2,292	\$275,052	\$275,052	0
CADI Waiver*	\$13,964,302	18.40%	9,892	\$1,412	\$6,982,151	\$6,982,151	0
TBI Waiver*	\$2,617,964	3.50%	1,295	\$2,022	\$1,308,982	\$1,308,982	0
Relocation Service Coordination*	\$910,129	1.20%	1,580	\$576	\$455,065	\$455,065	0
DD-County Contribution	\$5,964,391	7.90%	N/A	N/A	0	0	\$5,964,391
DD-CCSA	\$1,289,059	1.70%	N/A	N/A	0	\$1,289,059	0
DD-CWTCM*	\$2,267,476	3.00%	N/A	N/A	\$1,133,738	0	\$1,133,738
DD-MR/RC Waiver*	\$24,985,030	33.00%	14,803	\$1,688	\$12,492,515	\$12,492,515	0
DD-Other (gifts and contributions)	\$453,721	0.60%	N/A	N/A	0	0	\$453,721
DD-SSTS*	\$12,802,807	16.90%	N/A	N/A	\$6,401,404	0	\$6,401,404
DD-Title XX	\$1,027,058	1.40%	N/A	N/A	\$1,027,058	0	0
VA/DD-TCM*	\$8,986,753	11.90%	4,863	\$1,848	\$4,493,377	0	\$4,493,377
Total Developmental Disabilities	\$57,776,295	76.20%	N/A	N/A	\$25,548,091	\$13,781,574	\$18,446,630
Total Case Management	\$75,818,794	N/A	N/A	N/A	\$34,569,341	\$22,802,824	\$18,446,630
*Medicaid-Financed Case Management	\$67,084,565	N/A	N/A	N/A	\$33,542,283	\$21,513,765	\$12,028,518

In 2005, about \$55.8 million of total outlays (73.6%) were financed through Medicaid, principally via the CAC, CADI, TBI and MR/RC Waivers. County-funds (including county-funds that match federal Medicaid dollars) totaled \$18.4 million.

<sup>5</sup> Counties, for example, receive some state-only funding for special populations and some federal Title XX (Social Services Block Grant) funding for case management.

<sup>6</sup> Department of Human Services, Disability Services Division (February 2006). *Continuing Care Matrix of Services to People with Disabilities*, located at: [http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs\\_id\\_049281.pdf](http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_049281.pdf). The outlays included in the matrix are based on payments.

Between 2002 and 2005, case management expenditures increased by 41.4%. This increase can principally be attributed to the expansion of the CADI HCBS Waiver and the implementation of the VA-DD/TCM coverage in 2003 which enabled Minnesota to secure federal Medicaid dollars to offset county outlays under Rule 185. As a general matter, when measured (where possible) on a per person basis, case management costs expenditures were generally stable between 2002 and 2005. For example, the average cost of case management for MR/RC Waiver participants in 2002 was \$1,617 and increased by 4.4% to \$1,688 in 2005.

#### **IV. FEDERAL CASE MANAGEMENT ACTIVITIES IMPACTING REFORM PROPOSALS**

There are three recent federal initiatives which will possibly affect case management and support services for persons with disabilities, now and in the near future.

##### **1. Deficit Reduction Act of 2005**

This Act, also known as the Budget Reconciliation Act, has major provisions affecting numerous Medicaid and Medicare programs, and includes an overall reduction of \$39 billion in federal spending over the next five years for these programs across the country.

This act expanded statutory language concerning targeted case management services, especially concerning the allowable scope of TCM. This new language did not appreciably alter the scope of what could be covered. However, there is additional language designed to prevent states from claiming federal Medicaid dollars for activities that fall under Title IV-E (child welfare responsibilities). Minnesota anticipates a reduction of \$40 million in funds for targeted case management, primarily for child welfare in 2007, which has been addressed in this year's Governor's budget.

##### **2. CMS Quality Framework**

The federal Center for Medicare and Medicaid Services has developed a Quality Framework for Home and Community Based Services which serves as a frame of reference in improving the quality of services and supports for people with disabilities. The Framework focuses on the desired outcomes of Home and Community Based Services (Medicaid waiver) quality management and improvement efforts. Although it is not regulatory, it does provide a framework for certain expectations of quality outcomes for home and community based services. This includes the expectation that any state with these services is actively reviewing the quality of its community services system and planning for quality improvement.

##### **3. Choice of Case Manager**

One of the elements of the CMS Quality Framework is Freedom of Choice for consumers. One element in Freedom of Choice is participant choice of providers, including who provides case management for them. Waiver plans and waiver applications in several states, including Minnesota, have been challenged in federal reviews if there is a sole source of case management

such as Minnesota counties. While Minnesota was able to obtain a 1915(b)(4) waiver for the TBI Waiver program, allowing counties to retain responsibility for case management, choice of case manager will likely continue to be an issue.

Additional federal trends are also influencing states to examine and alter the ways in which they structure case management and their disability and aging services systems.

## V. PROJECT ACTIVITIES

The information and recommendations in this report were gathered from numerous sources, including reviews of Minnesota case management reports and administrative data, national reports, studies from other states, and professional case management literature. In addition, national experts nominated other states for their innovative case management models and practices, and representatives of these states were interviewed. The information gathered was reviewed with Minnesota stakeholders and the primary sources of recommendations contained in this report are from interviews and focus groups held with these Minnesota stakeholders.

### Minnesota Stakeholder Input

Input from Minnesota stakeholders was obtained from three primary avenues:

1. Interviews with representatives from 19 Minnesota counties.
2. Focus groups held in four geographic areas in September 2006.
3. A second series of focus groups held in the same four geographic areas in November 2006.

First, representatives from a sample of Minnesota counties were interviewed regarding their current policies, practices and procedures across all the disability groups. Recommendations of counties to interview were obtained from state and regional office personnel, to represent every region of the state and every size of county. The counties interviewed were:

Blue Earth	Lincoln	St. Louis
Brown	Lyon	Scott
Cass	Murray	Sherburne
Clay	Olmsted	Stearns
Cook	Otter Tail	Washington
Dakota	Ramsey	Wright
Hennepin		

A total of 71 county personnel from 19 counties were interviewed including case managers, supervisors, other county administrators, and public health nurses. The interview protocol can be found in Appendix A. Detailed analyses of these interview responses were shared in the preliminary project report to DHS in June 2006. A total of 22 themes or recommendations emerged from a review of interview notes.

Second, stakeholders were invited to attend focus groups held in New Ulm, Duluth, St. Cloud, and the metro area in September 2006. A total of 277 stakeholders from 33 counties attended, representing county case managers, case manager supervisors and other county administrators, families and persons with disabilities, and representatives of service provider agencies, disability advocacy organizations, labor organizations representing county social service workers, and managed care organizations.

Focus group participants were asked in open-ended questions to comment on the strengths of Minnesota's system and to identify areas needing improvement. Their responses were similar to those of the county personnel who had been interviewed. Participants also completed a survey composed of the 22 recommendations made in the county interviews, in which they were asked to rate their agreement or disagreement with these 22 recommendations (see the survey in Appendix B). A few stakeholders who were not able to attend the group meetings also responded to the survey. In addition, a version of the survey which contained only items directly relevant to consumers was also made available for consumer stakeholders. The results of these surveys documented a high level of agreement with the recommendations made in the county interviews, further reflecting strong consensus on which areas need improvement.

### **Innovative Models from Other States**

National experts<sup>7</sup> were asked to recommend innovative models of case management in other states and local areas. Some states were interviewed if they used a standard structure for case management services different from Minnesota's, and others were interviewed if they were recommended as being innovative. The format used to interview states is contained in Appendix C. A total of 29 people were interviewed, and information was obtained on 20 states from these interviews, state Web sites, and state reports.

Minnesota focus group participants also responded to a second survey in the September focus groups concerning the innovative case management models identified in these state interviews (see the survey in Appendix D). A description of some of these models from other states can be found in Section VII of this report.

### **Summary of Stakeholder Input and Development of Recommendations**

A detailed summary of the information on all the input areas provided by participants in the September focus groups can be found in Appendix E.

Recommendations based on the focus groups, county interviews, and state interviews were reviewed with DHS representatives in October 2006 and narrowed down to a refined list of the most significant recommendations. These were presented to the focus groups for additional

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<sup>7</sup> National experts were interviewed who have knowledge of case management systems for different disability groups. These experts included: John O'Brien and Connie O'Brien of Responsive Systems Associates; Michael Smull of Support Development Associates; Deborah Spitalnik of the University Center on Excellence, UMDNJ; K. Charles Lakin of the University of Minnesota; Robert Gettings, Chas Moseley, and Robin Cooper of NASDDDS; Valerie Bradley and Sarah Taub of Human Services Research Institute; Patti Scott of Neighbors, Inc.; Jean Tuller of Oregon Technical Assistance Corporation; and Lynda Kahn of Inclusion Press.

input in November 2006. These meetings were attended by 172 people, most of whom had also attended in September. A facilitated discussion approach was used, and comments by participants were used to develop the final recommendations made in this report.

## **VI. STRENGTHS AND WEAKNESSES IN MINNESOTA'S STRUCTURES**

This analysis of strengths and weaknesses in Minnesota case management policies and financial structures is based on comments, suggestions and recommendations made by stakeholders throughout this project and on information gathered from the review of literature and interviews of other states.

### **A. PERCEIVED STRENGTHS OF MINNESOTA SYSTEM**

Seven primary strengths of the Minnesota system, as identified by the stakeholders and by project personnel from interviews with other states, are summarized in this section.

#### **1. Strong working relationships**

County case managers and supervisors frequently mentioned strong working relationships, team systems and strong local connections as strengths of Minnesota's case management system. In the focus groups, consumers and families mentioned strong and long-lasting relationships with their individual case managers. Project participants were particularly appreciative of structures where one accountable case manager had a long-lasting relationship with specific consumers and families, and where strong interdisciplinary teams were present.

#### **2. Independent county role**

Many participants noted that offering case management services independently of service provision was a strength of Minnesota's system, allowing for the possibility of a strong advocacy role for case managers. In a few states, case management is embedded within the agencies providing service to an individual, which may lead to conflict of interest. Another strength of Minnesota's system identified by participants was having a single point of contact and accountability (i.e., the county).

#### **3. Federal financial participation is maximized**

Minnesota has been very effective in obtaining federal financial participation through Medicaid for case management for people with disabilities. DHS accesses multiple Medicaid funding streams that collectively contribute a significant share of state and county costs in furnishing case management. How Minnesota employs Medicaid financing was explained above in more detail in Section III.



#### **4. Flexible case management**

Minnesota's recently established option for flexible case management in the Consumer-Directed Community Supports (CDCS) service is considered a model by many other states for the flexibility and choice it allows consumers. However, many counties interviewed did not have sufficient experience with it to comment on the strengths or challenges of this option.

#### **5. Few grievances**

Several county interviewees noted that there have been relatively few grievances lodged in the Conciliation and Appeals process. These respondents frequently commented that consumer complaints are resolved before concerns reach this process.

#### **6. Strong established professional foundation for case management**

As in most states, case management for individuals with mental retardation and/or related conditions (developmental disabilities - DD) was the first well-established case management system. Minnesota Rule 185 governing services for people with DD has allowed for the establishment of strong systems and expectations regarding meetings, contacts, review guidelines, etc. There are qualified and knowledgeable case managers with professional standards of impartiality. In the first round of focus groups, particularly, it was clear that most case managers in the DD system were pleased with the quality of that system. As case management and waiver funded supports have expanded to other disability groups, the DD system has provided a foundation for establishing practices and policies for these other groups. This has, however, also led to certain weaknesses, described in the next section.

#### **7. Specialization concerning various disabilities**

The system allows for case managers and/or public health nurses to specialize in knowledge of specific disabilities. It is difficult for one case manager to know everything about every service and every disability. Counties have developed structures to bring together the knowledge from the different specialists, and many counties have established strong internal team systems to address the complexity of multiple disabilities. Particularly in the larger counties, those teams are often specialized by disability type and by age.

### **B. PERCEIVED WEAKNESSES IN CURRENT MINNESOTA STRUCTURE**

Participants in this project identified twelve major weaknesses in Minnesota's case management structure.

#### **1. Inequities Between Disability Groups, Counties and Funding Streams**

There are inequities in the type or amount of case management or other services offered to Minnesotans with different disabilities. There is a lack of consistency and compatibility in available services across the different waiver types for the different disability groups, with

variation of administrative processes, rules, standards and reimbursement from program to program. Many case managers have faced the task of gaining both the technical expertise and knowledge of different rules under many different funding streams to assist members of a wide variety of disability groups. Some requirements under Rule 185 for persons with mental retardation or related conditions are more stringent than for other groups. If a person receives case management funded through TCM, they also often receive more support than those whose case management is funded through other sources. In addition, persons who receive funding under a Medicaid waiver are usually eligible for more and different types of services supports than persons who receive support under other funding streams.

As one example of this confusing picture, many county personnel indicated that the monitoring requirements under the CAC, CADI and TBI Waivers were for one face-to-face visit a year, although two are required in the state's waiver plan. Table 1 in Appendix F shows some of the differences between these requirements for consumers. Differences in funding streams for reimbursement for just one cost, transportation expenses for case managers, are shown in Table 2 in Appendix F. These types of disparities between programs make for a confusing picture.

In some counties, public health nurses play a much stronger role in case management processes for persons with physical disabilities than in other counties. Some counties have a strong nurse-social worker team for individuals with physical disabilities and traumatic brain injury, in some only the public health nurse is accountable for similar individuals, and in other counties the social services case manager remains accountable. In some counties, individuals who are getting only Medicaid State Plan (non-waiver) services do not have any on-going service coordination.

In addition, procedures and rules vary within and between counties, often leading to confusion. There are multiple assessment processes and variation in quality from county to county and case manager to case manager. Stakeholders indicated that certain specific groups of consumers are relatively poorly served: people with mental illness, crisis services for children and adolescents, people with autism, people with both mental retardation and mental illness, people with mild/borderline intellectual disabilities that do not have an MR/RC Waiver slot, and people with severe disabilities who cannot express their needs or wants and have no family, friends or advocates.

## **2. Similar People Get Treated Differently Based on Different Funding Streams**

Since the Legislature has limited growth under the MR/RC Waiver, on some occasions people with these disabilities have been diverted to other waivers, which often provide less access to certain services. There is overlapping eligibility for programs; for instance, persons with mental retardation and related conditions are served under both MR/RC and CADI Waivers, and these waivers have differing requirements. A county sometimes will use whatever waiver "slot" is available to support an individual, while others with the same disability receive support under a different waiver. This results in situations in which some individuals with similar disability levels receive funding through different sources, and sometimes have fewer services than others based on which program they can access.

One concern of numerous stakeholders that kept arising during this project was that adults with mental health issues (Severe and Profound Mental Illness or SPMI) had not been included in the groups of people with disabilities under age 65 asked to be addressed in this project, except for those receiving services under the CADI Waiver. Again, there are different case management processes for similar individuals receiving services under different funding streams, which leads to inequities.

### **3. Access**

Access to case management and other services is often difficult and confusing, and many counties have waiting lists. Determining eligibility can often be confusing without clear definitions. A lack of clear eligibility definitions was particularly noted by interviewees and stakeholders for persons requesting personal care assistance (PCA). Since that service is a State plan service, many PCA recipients do not have access to ongoing case management. In some counties, public health nurses reported that they provide service coordination support to PCA recipients despite not having a source of funding to do so. One reason that inequities have emerged is a lack of federal or state dollars available to counties for case management for persons with certain disabilities, or for people who do not receive HCBS waiver services. Counties have different policies about how and for whom they will fund case management services out of property taxes.

### **4. Caseload Size**

During county interviews, caseload size was the most frequently noted system weakness. As one example, caseload size in Minnesota for persons with developmental disabilities exceeds the national average. Large caseloads do not allow the case manager to really get to know the person and their family and ensure person-centered quality services. Caseload size also impinges on case manager capacity to address crises.

### **5. Quality Assurance and Service Standards**

Many counties reported having a limited capacity for quality assurance. Monitoring for many services is primarily through the case management process of visits, contacts, and periodic reviews, rather than a more formal and independent process. Most counties reported wanting to do more quality assurance, but that they are limited by their case management reimbursement system to simply providing basic case management administrative and service coordination functions. In terms of the quality of basic case management procedures, there is great variation from county to county in capacity to determine if specific service standards are being met, such as if certain steps in the assessment or plan development process are completed according to deadlines. Some counties reported robust systems to do this while others said they were aware that they should be doing more but that they did not have the resources to do so.

### **6. Weak Coordination between Health Care and Continuing Care**

Because Rule 185 for Persons with Mental Retardation and Related Conditions requires a medical history as part of the services plan, often the medical needs of that group are better

addressed than for others. Medical information needs to be better addressed in the Comprehensive Assessment process and support plans for all groups.

### **7. Varying Responsibility for Persons Under Age 65 in Nursing Homes**

Many counties reported taking an active approach to relocating persons under age 65 from nursing homes, but only when they are requested to do so; few engage in pro-active relocation efforts. There is a wide variation in the extent to which county social services have become involved in efforts to divert people under age 65 from entering nursing home placement. There are formal processes missing for the linkage between social services, hospitals and nursing homes to effectively divert people to community services, which can often be less costly.

### **8. Complexities of Consumers Moving to Different Counties**

When an individual from one county moves to another, host county arrangements are often cumbersome and unworkable.

### **9. Dual Case Management**

Some situations with dual case managers are confusing and duplicative. These situations include individuals with both mental health and waiver case managers, and in some cases when case managers and public health nurses each play a role in supporting individuals with physical disabilities or complex health concerns. (These challenges were well described in the April 2005 report to the Legislature.)

### **10. Need to Separate Guardianship and Case Management**

For state wards, the dual county role of public guardianship and case management is perceived as a weakness, leading to an undue burden of potential conflict of interest.

### **11. Creativity and Change**

There is a perception that individual county capacity for creativity with services and resource options has become more restricted. Any changes from DHS should not simply be imposed but should be implemented with effective ownership by counties and other involved stakeholders.

### **12. Cumbersome Paperwork, Documentation, and Financial Structure**

The maximization of federal dollars for case management has led to a complex documentation and financial structure. The price that is paid for securing these funds is administrative burden at the county and case manager levels. These burdens are explained above more fully above in Section III, an analysis of current Minnesota fiscal structures for case management.

## VII. COMPARISON OF MINNESOTA TO OTHER STATES

We conducted a literary and practical review of case management practices, models, funding and performance standards used by other state Medicaid agencies through searching out case management reports, collecting information from state Web sites, interviewing representatives of other states, and reviewing case management literature. We asked national disability and human services experts<sup>8</sup> for recommendations of innovative case management models. Information was collected on state efforts in twenty other states. This section compares Minnesota to other states in seven service system and case management dimensions.

### 1. Governance Structure

One of the primary differences between Minnesota and other states is its governance structure: Minnesota is a state-regulated, county-administered system. A total of 12 states, including Minnesota, administer human services through such a system, including the nearby neighboring states of Wisconsin and Michigan. Strengths of county-administered systems include local control and accountability, as well as use of local tax revenue. Other states regulate human services and provide case management through a single state-administered system, with regional offices for more local contact. A state-administered system often allows for more equitable administration of policies and procedures, as well as a central database. Such a structure also often allows other states to more easily implement a complete overhaul when certain changes are implemented.

A few states use other structures such as private case management agencies, contracted independent non-profit entities which provide case management either regionally or statewide, mixed public and private systems, and case management through service provider agencies.

### 2. Definition of Case Management

Case management has two key features: (a) providing an interface or connection between individuals with disabilities and the system of publicly funded and generic services and supports; and (2) assuring that these services meet reasonable standards of quality and lead to important life outcomes for individuals (Cooper, 2006). In Minnesota, three broad case management responsibility areas were described by county personnel who were interviewed:

1. administrative functions such as screening, eligibility determination, plan development, and monitoring;
2. on-going service coordination;
3. advocacy, hands-on support, and traditional “social work.”

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<sup>8</sup> National experts were interviewed who have knowledge of case management systems for different disability groups. These experts included: John O’Brien and Connie O’Brien of Responsive Systems Associates; Michael Smull of Support Development Associates; Deborah Spitalnik of the University Center on Excellence, UMDNJ; K. Charles Lakin of the University of Minnesota; Robert Gettings, Chas Moseley, and Robin Cooper of NASDDDS; Valerie Bradley and Sarah Taub of Human Services Research Institute; Patti Scott of Neighbors, Inc.; Jean Tuller of Oregon Technical Assistance Corporation; and Lynda Kahn of Inclusion Press.

Currently the degree to which any citizen with disabilities in Minnesota receives all these three types of support depends on their type of disability and funding stream. For instance, some individuals with physical disabilities or traumatic brain injury receive only assessment, eligibility determination and referral to services, with no on-going service coordination, since it is neither funded nor required unless a person receives Medicaid waiver funding.

The professional literature about case management models points to five possible roles or functions for case management:

1. Administration
2. Crisis management
3. Consumer empowerment
4. Individual advocacy
5. Systems advocacy

These roles could be seen as additive, going from the most basic and required functions to roles that are desirable but beyond the minimum required ones. At a minimum, the Minnesota case management system allows for fulfillment of the first two of these roles, mixed fulfillment of roles three and four, and a few occasions for systems advocacy. A fundamental question in the design of a case management model is which of these roles should be fulfilled by whom.

The role of a case manager and definition of case management in Minnesota differ from more innovative models in other states which have more strongly developed programs for self-determination, consumer empowerment and self-direction. Examples of such programs are in Oregon, New Jersey, some Wisconsin counties, Maryland, Vermont, and New Hampshire. The other original Robert Wood Johnson Foundation self-determination pilots and the Community Supported Living Arrangements (CSLA) pilot states also provided models for how to establish such programs. The typical design in these programs is that an individual receives an allocation and has control over how that allocation is used. A foundational principle is that a major part of the support role is to assist individuals to determine the most creative and best use of their allocated resource dollars to design the most personally tailored support package possible. In most progressive self-determination models, support packages are individualized, are not reliant on congregated/small group support models, and involve family, friends, and natural community supports. (“Individualized support does not mean that people spend their time alone. Many individuals share their homes with chosen others and have good relationships with co-workers and fellow citizens. Service design for individualized support starts with a person rather than with any sized facility for labeled people and finishes with personally tailored supports that strive to change as people’s capacities and opportunities to participate in community life do.” O’Brien & O’Brien, 2006, p. 10).

The most innovative service models in other states are those that incorporate the principles of self-determination and consumer empowerment, including consumer control of their services budget. In these, the definition and role of a case manager changes to more that of a support coordinator, who assists the individual in designing an individualized, self-directed, community-supported life. For example, in New Jersey’s Real Life Choices program<sup>9</sup>, individuals may not

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<sup>9</sup> [www.fscnj.org/rlcprovover](http://www.fscnj.org/rlcprovover)

purchase any services from traditional congregated services such as group homes or day programs. There are currently about 600 people receiving service in this program, which started with persons on the waiting list but has expanded to persons leaving institutions and transitioning from high school to adult services. The support coordinator facilitates the plan development, connects the individual and family to community resources, and assists the person to design and purchase individualized support. The person may also get additional assistance in developing a career and identifying and locating the place they would most like to live. The program also has family and peer mentors, who are individuals (or their family members) who are already living on their own in the community and have community careers. The mentors help other individuals with disabilities and their families think through the person's plan and develop natural supports and connections to have a community life. The traditional case management role is only that of monitoring. This program has a high level of consumer satisfaction.

While some Minnesota case managers provide support coordination services to people receiving CDCS, the roles and structures in Minnesota's CDCS program are not as defined and true to self-determination principles as some programs in other states. While some Minnesota service recipients have very well developed, individualized and personalized community support systems, many individuals and families purchase traditional services with their CDCS dollars.

Some Minnesota case managers noted that they have begun to incorporate more the idea of being a "service broker" rather than a "case manager," especially for people receiving support through the CAC, CADI and TBI Waivers. Service brokering involves directing people to needed services, coordinating payment for those services, and empowering the consumer to manage them. Other states have formally shifted their definition of case management to that of "support coordination" and/or "service brokerage."

### **3. Innovative Efforts – Support Structures for Self-Determination**

States such as New Jersey, Delaware, and Maryland are addressing the challenge of diminishing resources for case management by increasing their efforts in self-determination and consumer control over their services allocation. Key elements of such a design include an assessment process which leads to a determination of an allocation (similar to many Minnesota county CDCS processes), and major support in assisting individuals design the support to purchase with their services dollars.

Another element in such programs is maximizing the use of informal support mechanisms before using paid services. Minnesota's May 2005 Medicaid waiver report (Johnston, Villegas-Grubbs & Associates, 2005) noted that such use of informal support mechanisms was often missing in case management practices here, in sharp contrast to other states where case managers are instructed to always examine the availability of informal supports before authorizing paid services.

One example of a well-developed program is the above-mentioned Real Life Choices program in New Jersey ([www.fscnj.org/rlcprovover](http://www.fscnj.org/rlcprovover)), in which individuals receive an allocation but are not allowed to purchase any traditional or congregated services with their allocation (e.g., group homes, day training, and habilitation support). Critical support roles include a monitor (the only

traditional case management role), a support coordinator, a family/peer mentor, and specialized services such as a facilitator of a circle of friends which helps the person design their life and support system.

#### **4. Efforts Across All Disability Groups**

We found a few states (e.g., Maryland, Washington) that were working on systematically addressing equitable policies, procedures, and efforts across all disability groups, and attempting to bring all services for people with disabilities under age 65 together in a unified system. The state of Washington is undertaking a significant systems coordination effort to improve coordination across populations and services, and to improve their use of information technology to support such a coordinated system. They have 15 major initiatives to better coordinate the system and break down the separate “silos” of services, across not only all their disability groups but also corrections, children’s mental health, and other groups. They have developed and are refining an information management system in which information flows from assessment, to planning, to monitoring, to incident reporting, to quality assurance, across all these groups. One element of this coordinated system is a single entry point that provides easy access for any person with a disability.<sup>10</sup>

Michigan also uses a coordinated effort, with a county structure in which both persons with developmental disabilities and those with mental health issues are supported in a single county administrative unit.

#### **5. Efforts to Deal with the Challenge of Decreasing Resources**

Virtually every state is faced with the same situation as Minnesota – increasing numbers of consumers in the face of diminishing case management resources and diminishing resources for direct services. States are attempting to address this challenge in a variety of ways. Delaware made a commitment similar to Minnesota, to develop reform proposals to identify more effective ways to design case management. Their approach is to clarify the state’s vision for the whole services system, identify larger systems changes such as increasing self-determination, and then determine the role of case management or support coordination inside that vision. They are clear that any changes must result in people having better lives.

To address high caseloads and limited resources, New Jersey is implementing a formal tiered case management support system for persons with developmental disabilities. As a state-administered program, the state reviewed all people with DD receiving services and identified many individuals on case management caseloads who did not actually need on-going case management. These consumers need information, education, referral, and a source of connection to the system when there are problems. Many in this group are children living at home with minimum services such as in-home support or respite services. This group was placed into a new program called “Connections” with a minimum level of case management identified as “Resource Case Management.” Phone contact is maintained at least once annually.

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<sup>10</sup> More information about initiatives in Washington State is available at <http://www1.dshs.wa.gov/ddd/CMIS.shtml>; <http://www1.dshs.wa.gov/ddd/CMIS.shtml>.



People receiving waiver-funded services were divided into either Program Case Management or Primary Case Management. Program Case Management is provided to individuals who are enrolled in structured service programs in which there are other sources of regular oversight, such as group homes, supervised apartments, and day programs. Visits are required quarterly, but caseloads have been divided so that the resources of one case manager can be used to visit several individuals at the same service site. Program case managers have approximately 90 people on their caseloads. Primary Case Management is reserved for those who are the most vulnerable, and caseloads are limited to 35 service recipients to allow for monthly contact. This is the way one state is addressing the challenge of expanding caseloads with limitations on resources.

## **6. Performance Standards – Outcomes of Case Management**

It is challenging to determine the outcomes of case management, such as what individual life outcomes result from an individual having a case manager. Previous controlled research studies which assessed whether case management made any difference, and studies of the effectiveness of different case management models, have yielded mixed results regarding costs, satisfaction, and life outcomes (e.g., Zimmer, Eggert & Chiverton, 1990). The challenge is due to the interwoven complexity of the services system; case management does not operate in a vacuum separate from the quality of the services system or services funding.

Other states measure consumer satisfaction and case management outcomes using expanded quality assurance efforts which assess overall quality of people's lives. Examples include accreditation reviews (e.g., The Council on Quality and Leadership) or the National Core Indicators, which measure a state's overall performance on a number of quality of service indicators (Taub, Bradley & Smith, 2003).

Some states have improved the determination of whether case managers are meeting process deadlines and standards (e.g., schedules for completed assessment, frequency of annual plan review) through developing an effective management information system, discussed above.

## **7. Funding**

Differences with funding of case management in other states is addressed separately, and is described in Section III above and the section concerning simplification of Medicaid funding (Recommendation #5 in the next section).

# **VIII. PROPOSED MAJOR RECOMMENDATIONS**

Based on our literature review, study of national trends, and surveys and focus groups with Minnesota stakeholders, we conclude that a functional system of case management for Minnesotans with disabilities would be one which:

- Is as streamlined as possible;

- Effectively links referred individuals with disabilities to the system of publicly funded and generic services and supports;
- Assures that services meet reasonable standards of quality and lead to important life outcomes for individuals;
- Supports consumer control and choice as much as possible, while maintaining minimum performance measures and standards;
- Allows for individual service recipient’s choice of case manager for service functions such as ongoing service coordination;
- Adequately funds county and private case management providers for both administrative and service coordination functions; and
- Adequately funds caseload sizes which allow for effective and accountable support and realization of person-centered goals.

Any reform efforts should, if possible:

- Improve service availability
- At least maintain and if possible expand current capacity
- Improve consumer access to needed services and supports
- Improve accountability

For Minnesota, a functional administrative structure would be one which retains county responsibility for administrative functions: intake, eligibility determination, assessment, plan approval, service authorization, budget allocations for the service plan, and on-going monitoring of the quality and outcomes. A key element of a functional system is having funding, billing and information systems that adequately support these functions.

Again, it is important to remember that case management is only one element of a broader system – simply making changes in case management will not address all of the system challenges. There is no one “magic bullet” that will solve all problems. Given current federal funding and rule constraints, there are up-sides and downsides to almost any recommendation.

## **KEY RECOMMENDATIONS**

There are six key recommendations which were summarized in the first part of this report and are described in more detail in this section.

### **RECOMMENDATION #1. STANDARDIZE AND SIMPLIFY PROCESSES**

The most frequent recommendations from county interviews, which were validated by the highest rates of agreement in the stakeholder surveys, concerned stream-lining and simplifying case management processes across all disability groups. Processes across funding streams and waivers can be standardized and simplified, including a Comprehensive Assessment process, standard plan format, and common menu of service options across waivers. There are four major recommendations in this area.

## **A. CONTINUE AND EXPAND EFFORTS TO STANDARDIZE AND SIMPLIFY PROCESSES**

In terms of standardizing and simplifying processes, these were the major recommendations from stakeholders:

1. Streamline processes for all disability groups – one service plan, one release of information form, a Comprehensive Assessment process, and universal service standards.
2. Improve the assessment process for personal care assistance.
3. Have a common menu of direct service options across all waivers, and simplify provider billing across all the waivers.
4. Establish consistency in resource allocation across all waivers – establish a universal way to set benefits.

DHS staff indicated that plans are already in place addressing the first three of these four recommendations. The recommendation with the most progress to date is the Comprehensive Assessment protocol ([www.hcbsstrategies.com/univassess.htm](http://www.hcbsstrategies.com/univassess.htm)), described in the April 2005 report to the Legislature; this instrument is currently close to being piloted. Use of this assessment tool will begin with people eligible for Medicaid waiver programs, but the plan is to expand its use to people who would receive services under other funding streams. Refinement of this tool will help address the current complexities in the assessment process for personal care assistance. Once the Comprehensive Assessment process is established, other components such as a universal service plan and release of information can be developed. A project for a common service menu is already underway. The fourth recommendation concerning consistency in resource allocation is more difficult, but could be pursued.

Stakeholders who attended focus group meetings recommended the following concerning the Comprehensive Assessment process:

- Need to pilot in both rural and urban areas
- Take the time needed for it to really work
- Need to ensure sufficient technology is available locally
- Need for on-going stakeholder involvement
- Must be mandated or it will fail
- Ensure all needs are addressed, including medical, behavioral, and children's functioning levels
- Reduce the cumbersomeness of documents
- Must be able to individualize the format
- Must have sufficient training for consistent use
- Needs to also include health information, and address confidentiality concerns to obtain that information

This was input concerning a universal plan from the stakeholder focus groups:

- There needs to be one objective “gatekeeper” of the plan when multiple parties are involved
- There needs to be a technological system to allow various individuals to contribute to and modify the plan
- The gatekeeper should coordinate the approval of the plan elements and modifications

One critical element to ensure adequacy in both individual assessment processes and in plan development is that there is coordination between programmatic support with basic health and medical care. The current system design separates basic health care and long-term continuing care into separate “silos,” but comprehensive planning for an individual’s life requires bringing them together. We found many excellent examples in Minnesota counties in which public health nurses were playing a critical assessment and support role, and in which social services and public health had built effective and strong teams both for assessment and for on-going service coordination.

## **B. INVEST IN A COORDINATED, STREAM-LINED SYSTEM FOR SUPPORT TECHNOLOGY**

A key part of a more coordinated system would be a well-designed, consumer-friendly management information system that can simplify, streamline, and make as comprehensive as possible the process of collecting and using information concerning individuals who request and receive support. A comprehensive information system in which information flows from intake to assessment to planning to monitoring to incident reporting to quality assurance, which is linked to other needed database systems, could greatly improve access and on-going service coordination across all disability groups. If duplication can be reduced, case management and case aide time devoted to consumers can be increased. With such an information system, inequities between groups, individuals and counties could be reduced. Monitoring of performance standards (Recommendation #2 below) could be greatly enhanced. DHS currently has a Quality System Architecture project in place, aimed at modernizing and redesigning its information technology systems. One part of this project is to identify specific issues related to such an information system.

There were many concerns expressed by stakeholders in this project about Minnesota’s current database systems, especially the Medicaid Management Information System/Social Services Information System (MISSES). Some counties use this system to track case management activities and perform billing. Other counties have developed their own information technology systems (e.g., CCM -- Client Contract Manager/Client Case Management system) to meet local needs and feed their data into the state system. Counties say the CCM system provides more usable reports but is expensive for counties to purchase. The operation of redundant IT systems raises the costs of furnishing case management. Over the long-term, it is important that state and county IT systems converge into a single system that meets the needs of all users. The May 2005 report to the state on a resource allocation methodology for waiver services (Johnston et al., 2005) also noted the problems of the current system and the need for a much more comprehensive, streamlined database system.

A well-designed information system could also impact equity in access. Potential consumers could provide some information on-line as the first steps in the intake process. If case information was available online, an individual already receiving support who called in for help or information could be assisted by a variety of individuals in a more efficient manner; the consumer would have the opportunity to receive immediate assistance rather than wait for their case manager to return their call. In addition, a linked information system could assist in the coordination of social services with basic health care, financial data, and other relevant information.

In the focus groups, stakeholders were presented with Washington state's model for a comprehensive database system. Based on this model and their own experiences with Minnesota's current system, stakeholders indicated that:

Database system should:

- Be comprehensive: with information moving from intake to assessment to planning to monitoring to incident reporting to quality assurance, across all groups
- Be user friendly
- Be based on "real time" data
- Not be as cumbersome (as the current MMIS/SSIS system)
- Be linked to other data-bases (e.g., financial authorization data)
- Have useful reports like CCM
- Have "ticklers" for reports (e.g., VA reports, 45-day reviews, etc.)
- Have an "auto fill" feature (e.g., name, address, MA number)
- Make previous plans readily available to be modified
- Provide "smart templates" to reduce record keeping and record-seeking time

Besides these recommendations for such a system, stakeholders also expressed some concerns that would need to be taken into account: confidentiality, need for sufficient training, and that an automated database system could become "impersonal" if a caseworker were using a laptop at a consumer's home.

Stakeholders also indicated a need for increased information and assistance to consumers. Their recommendations included providing a data-base or Web site information for families with information about what to expect from case managers, what to expect from providers, and information on provider performance.

### **Information on Database Systems in Other States**

Other states have already developed or are working to develop the type of coordinated database system which Minnesota stakeholders have advocated.

Pennsylvania, for instance, developed a database system called Home and Community Services Information System which cost about \$50 million. The state contracted with an outside

technology company and this site has won Information Technology awards.<sup>11</sup> Its design strength is changing the business model from a basis in county contracts to an organizing foundation around the individuals who receive support. Counties are simply instruments in a larger picture business model organized around the individuals – their enrollment into the system, their service plan, etc. The main focus is the people who are enrolled in the service, and counties are the entities through which business is conducted. This system is also modularized, so other states can use different modules, which Massachusetts is doing.<sup>12</sup> When a database system is not developed the right way, it can be very expensive. California designed an information system for people with developmental disabilities which is now being abandoned after seven years.

Washington State has also implemented a universal assessment process and is implementing a Case Management Information System in January 2008. This system was developed in Oregon for \$20 million, but Washington State paid the contractor \$2 million to \$3 million to adapt it to Washington. The system links financial information to clinical data, has reduced errors, tracks minimum requirements being fulfilled, and assists in more uniform enforcement of policies. It has been called a “case manager’s dream.”

### **Potential Costs**

As described, states like Oregon and Pennsylvania have invested from \$20 million to \$50 million to develop such coordinated databases. Rather than reinventing the wheel, some or all of these systems can be purchased from these other states and adapted to Minnesota at reduced cost. One possible scenario is a cost of \$2 million to \$3 million.

### **C. IMPROVE AND EXPAND INFORMATION AND REFERRAL**

Another element in a comprehensive and well-coordinated system is an adequate and useable information and assistance system. Part of the work currently done by case managers is navigational, providing consumers with information about services and supports. This type of support could be provided through Web sites and/or an improved information and referral system. In addition, streamlining and systems coordination efforts in other states across disability groups have included a significant role for “One Stop Access” entry or “No Wrong Door” access.

An effective information and assistance system at both the county and state levels could reduce time currently spent by case managers in this role. It could replace at least part of the navigational function played by many case managers, for example, by providing effective triage to needed services. It is likely that more consumers who call in for assistance could be directed and connected to appropriate generic agencies rather than becoming dependent on county social services. In addition, more individuals could be initially screened for eligibility for disability

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<sup>11</sup> Pennsylvania: <http://www.oit.state.pa.us/oaioit/cwp/view.asp?A=4&Q=198362>.

<sup>12</sup> Massachusetts: [http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Virtual+Gateway&L4=Overview&sid=Eeohhs2&b=terminalcontent&f=vg\\_g\\_about\\_virtual\\_gateway&csid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Virtual+Gateway&L4=Overview&sid=Eeohhs2&b=terminalcontent&f=vg_g_about_virtual_gateway&csid=Eeohhs2)).

services, receive information about connecting to different services earlier in the process, and thus have improved access. Web site information for consumers about services and eligibility could also be expanded and improved.

Stakeholder focus group members also expressed recommendations regarding a “One-Stop Access/No Wrong Door” consumer access:

- “First stop” personnel must be knowledgeable, and provide efficient and useful direction to the consumer (staff should know all the systems and waivers)
- Technology needs to be in place to pass the information along from the information and assistance/intake person to other appropriate staff or offices
- Need to sufficiently train staff

The state’s Disability Linkage Line can be better used to collect data on consumer needs, as the Senior LinkAge Line™ does. Information should be collected on what happens to the individuals who ask for help on this line, how they are linked to determine financial and service eligibility, etc. An adequate database management information system (as described in Recommendation #1.B. above) could also be used to collect such information.

#### **D. CONTINUE TO IMPROVE BUSINESS PRACTICES**

Many county informants also requested assistance in improving their business practices. They indicated a need for DHS to provide more assistance to counties with rate setting and the new business practices required under different programs.

#### **RECOMMENDATION #2. STANDARDIZE PERFORMANCE MEASURES AND MAXIMIZE INDIVIDUALIZATION**

The quality of case management can be assessed in two ways:

##### **1. Consumer Satisfaction – Life Outcomes**

Consumers’ satisfaction with case management support is often tied to their satisfaction with their support services and with their life circumstances. The real effectiveness of case management is tied to what life outcomes are being realized. Multiple factors in the overall services system and community affect those life outcomes, including the availability and quality of certain services, the degree of commitment of support providers, availability of personally tailored supports, the presence of family and friends, etc. Measuring the overall effectiveness of case management therefore can only be tied to larger quality assurance approaches. While some Minnesota counties periodically survey consumers about satisfaction with case management, it is difficult to separate this from satisfaction with services and with a person’s overall life situation. The determination of the quality of case management should be tied to more significant quality assurance initiatives, as are currently being proposed to the Legislature ([www.qapanel.org](http://www.qapanel.org).)

## **2. Process Measures**

The quality of a county's or case manager's performance can be determined by monitoring whether certain procedures and processes are being implemented in a timely fashion and according to requirements. Sample measures include the amount of time from intake to services, whether assessments are completed by the due date, whether people's needs are reviewed periodically, if all required elements are in a service plan, etc.

What can be measured most distinctly about case management performance, then, is how counties are fulfilling on the process measures and administrative functions described in #2 .

### **Need to Standardize Performance Measures**

A minimum expectation for expected outcomes of case management is timely fulfillment of such administrative responsibilities as screening, eligibility determination, assessment, plan approval, annual plan review, and redetermination of eligibility. However, different performance measures and timelines are in place in different programs for some of these functions. Timelines and certain protections are only available to certain groups and not to others. Due process requirements vary for different disability groups, as do the screening processes. For example, 60 days are allowed for a diagnostic evaluation of a person with developmental disabilities, but only 10 days from referral for an assessment of someone requesting support under the CAC, CADI or TBI Waivers. Mental health managed care plans have required timelines for scheduling appointments.

The various funding streams available for case management and for direct services have created a hodgepodge of requirements, with different individuals on different timeframes for assessment, planning and monitoring. These variances are due to the requirements of the individual funding streams rather than being due to differences in individuals' needs. For instance, Rule 185 governing services for persons with mental retardation and related conditions is the only such rule mandating case management, while requirements for case management are different under those programs funded with TCM and the different Medicaid waivers. Table 1 in Appendix F shows some of these different requirements.

Standardizing timelines and other performance measures would assist in streamlining of processes. County representatives in interviews and stakeholder groups recommended standardizing service standards across the disability groups and funding streams. There should be consistency of timelines established at least across all the Medicaid waivers, for such tasks as:

- screening
- assigning a case manager once a person is determined eligible
- length of time in which assessment is completed
- length of time in which initial service plan is completed after assessment is done
- annual review of the plan
- time in which complaints are responded to
- time in which intervention is provided when a crisis develops



Another possible direction is to have universal performance standards and requirements for all the disability groups under age 65. Examples of standards in other states for different subgroups or funding streams are displayed in Table 3 in Appendix F.

### **Expand Individualization of Performance Measures**

There are two contrasting values in the design of support services: first, that all services, including case management, should be as individualized as possible, to best meet each person's unique needs and situation. At the same time, this must be balanced with the second value: that basic protections are assured and that at least a minimum level of quality is being met.

In a model program, case management support would be as individualized as possible, based on the person's needs. Available resources should be prioritized to serve people according to their respective support needs. One example of the conflict between required timelines and individual need is TCM, which currently requires quarterly face-to-face visits for vulnerable adults and monthly phone contact for child welfare. TCM reimburses based on the number of visits; case managers in this project reported many instances of having to visit or call more frequently than the consumer needs, in order to capture as much funding as possible.

One way to increase individualization is to adapt certain performance measures to use individually determined schedules or standards as the performance measure for monitoring. Timeframes for certain performance measures could be established based on a particular individual's needs, with an interdisciplinary team making the determination of the timeframe or schedule. For instance, the performance measure for frequency of face-to-face visits or number of plan reviews within a year could be established by the team. Such an individualized approach is already used in developing Risk Management Plans in Minnesota, and is also used for provision of certain case management functions in other states' self-determination programs. The team's decided schedule would then be the measure that is monitored.

The November focus groups were asked for input on simply this one standard: how many face-to-face visits between the case manager and consumer should occur during the year? Stakeholder views differed on whether that minimum should be one or two visits across all disability groups.

#### **Example of Individualization: Number of Face to Face Visits in a Year: Alternative #1**

One stakeholder proposal that increases individualization but still assures a minimum standard would be a requirement for at least one face-to-face visit a year with the total number of visits determined by the interdisciplinary team. There would be flexibility for the total number of visits and contacts beyond the one required within a year, which total would be determined and planned by the team. Criteria for determination of the quantity of visits could be similar to criteria already used for risk assessment plans, including services received, age, service stability, health, level of natural support, etc. In addition, consumers and families would need to know they can get additional help whenever it is needed.

If such a standard (frequency determined by the team but a minimum of one annual visit) were instituted, current rules and waiver plans which require two visits a year would need to be changed to allow more flexibility as determined by the team. Also, some of the Minnesota state-funded (non-waiver) programs like PCA services have fewer visits required. Establishing equity in this standard for all funded programs may mean an increase on requirements for case manager time, or be balanced out between increases and decreases.

### **Example of Individualization: Number of Face to Face Visits in a Year: Alternative #2**

An alternative direction for increased individualization is to adopt the principle that the number of required visits should stay at two visits a year for all persons on any waiver, with a different minimum for non-waiver recipients, but that more input from the team on frequency of face-to-face visits should be part of the process. While the basic standard of two visits a year might be maintained, allowance could be made for exceptions or waivers of that requirement, based on a team decision. For example, in Pennsylvania guardians can request exceptions in writing to the number of required minimum visits. (Appendix F, Table 3)

In addition, there are two other ways to increase individualization. Information and assistance efforts can increase consumer empowerment and reduce dependence on case management. Secondly, stakeholder focus groups raised the concern about the growing need to address diversity, including the need for more training and support to address cultural competence, overcome language barriers, and address disability-specific issues.

### **Monitoring County Performance**

County waiver review reports indicate a wide variance in whether counties meet required timelines and on whether other performance measures are being met. Examples of performance measures in which there is great variance from county to county include: meeting screening timelines, service plans including all required components, case managers establishing the contracts with service providers, guardianship requirements being met, case managers signing off on screenings, and whether newly authorized services are increased without a new assessment. There are wide variances in expenditures county to county for the same programs such as supported living services, and in monitoring whether allowed services are actually being delivered.

As discussed previously, monitoring of all such standards could be improved through a comprehensive management information system. Such improvement has happened, for instance, in Washington State when it began piloting its well-developed Case Management Information System. Secondly, quality of performance is likely affected by caseload size. Performance could be improved through reducing caseloads statewide and ensuring that case management resources are comparable county-to-county (see discussion in Recommendation #6 below). Lastly, the role of DHS should be one of technical assistance aimed at “raising the bar” and assisting counties to improve performance. For instance, ongoing regional or state forums could be held or information shared in other ways concerning effective management tools, business process designs, problem solving, and data collection. Individual counties could develop quality improvement goals and plans concerning these areas.

## **Potential Costs**

Several recommendations in this report will impact the area of performance measures and increasing individualization, including the management information system in Recommendation #1.B. above and standardizing caseload size in Recommendation #6 below.

However, in light of the linchpin role that case management plays in Minnesota in supporting people with disabilities in the community, Minnesota should make a continuing investment in case management technical assistance and performance improvement. It is recommended that an amount equal to one percent of total annual case management expenditures be earmarked for this purpose (i.e., approximately \$750,000). These funds would be available to DHS to furnish technical assistance and to engage in system-wide quality improvement projects.

## **RECOMMENDATION #3. INCREASE OPPORTUNITIES FOR CONSUMER CHOICE OF CASE MANAGER**

When Minnesota's waiver application for persons with traumatic brain injury was being reviewed by a federal CMS panel, they questioned Minnesota's design in which the counties are the sole source of case management. One of the elements of the CMS Quality Framework is promoting more self-determination and consumer control over services, including consumer choice over who provides case management. Minnesota pursued and obtained a 1915(b)(4) waiver for the TBI Waiver that will continue the status quo, allowing counties to continue to be the sole source of case management but able to contract with other agencies if they choose. However, the issue of choice of case manager is likely to continue to arise during waiver application processes and will likely continue to be an issue in federal waiver application reviews, affecting the state's capacity to capture federal dollars. In addition, consumer, provider, and advocacy stakeholders in this project strongly agreed that increasing consumer choice of case manager should be pursued. DHS is already pursuing some efforts to promote free choice of case management provider, as in the Medicaid Plan amendment for Home Care Targeted Case Management (HC-TCM) and Relocation Service Coordination (RSC).

Minnesota already permits counties to contract out case management. Most counties already do have some private contracting, but in most, it is for some special purposes, such as:

1. contracting to provide case management for service recipients who live geographically far from their home county; and
2. case management to specific populations or for specific services, such as mental health case management or case management for individuals whose primary language is not English.

However, some counties have shifted a considerable amount of their case management workload to non-county vendors. In some cases, this has been to reduce county case manager caseloads and to control overall case management costs. These vendors function as "overload" providers of case management and, therefore, give counties more flexibility in managing caseloads.

As a general matter, contracted case management is less costly on a per-person basis than county-furnished case management. However, some counties have observed that the actual cost savings that arise from contracting out case management are less than they appear at first glance due to county contract oversight costs and the need for counties to provide training and support/technical assistance to contracted case managers. Still, to the extent that contracting out case management is expanded, the overall effect would be to dampen per-person case management costs.

One required element for increasing consumer choice is expanding the number of private agencies offering case management. However, simply expanding the number of private case management agencies as an alternative to county case management does not ensure real and meaningful choice. More must be done to ensure such choice. Consumers do not necessarily experience real choice by simply being provided a list of potential case management agencies, or being provided the choice of county case management versus one private agency. Consumers should have opportunities to meet potential case managers, have opportunities to hear from other consumers about different case managers or case management agencies, and be afforded other means to experience real market choice.

### **Recommendations and Guidelines**

Many states operate entirely non-public case management systems and some provide for open enrollment of case management providers in their Medicaid programs, a policy that enhances consumer choice. For example, in the Florida developmental disabilities system, *service coordination* functions are purchased exclusively from private agencies while the state retains *gatekeeping* responsibilities. We recommend that Minnesota consider restructuring the present county-centered case management platform along these lines. It is also important to retain a public case management system to serve an important safety net function for consumers.

Increasing opportunities for choice of case manager for Minnesota consumers with disabilities involves several tasks: separating the administration and service functions of case management, expanding the number of private agencies providing service coordination, and structuring opportunities for meaningful consumer choice.

In any design of case management support, some principles include the following:

- It should be provided locally, by individuals who know the community resources available
- It should be impartial, by individuals who do not have a vested interest in any service providing agency
- Case managers and the case management system should be accountable

In developing a system for increased choice, three structures we recommend are:

1. County retains the administrative roles of gate-keeping, other administrative functions, and quality assurance.

The county should continue to retain the administrative roles of screening, eligibility determination, plan approval, service authorization and quality assurance. Consumers should have a choice over who provides on-going support or services coordination. County case managers would then be using their expertise for screening, eligibility determination, and quality assurance, rather than for on-going support, community connecting, etc.

If the county retains these roles, different funding arrangements would be needed to reimburse these administrative functions. The April 2005 report to the legislature on case management also referenced this need. Recommendations in this report for alternative funding streams are in Recommendation #5 below.

## 2. No conflict of interest.

We recommend that private case management be free of conflict of interest. This could be fulfilled in one of two ways:

- No agency which also provides direct services could be allowed to provide case management
- If an agency which provides direct services wanted to also provide case management, they could not provide case management for any individual for whom they provided other services

## 3. Meaningful consumer choice.

Some structure would have to be instituted for individuals and families to meet potential case managers and be provided with guidelines for making a decision. Meaningful choice would entail more than simply being provided a list of potential agencies, or being offered the county versus one other agency.

### **One Model for Choice of Case Manager**

One of the innovative models for choice of case manager is in Dane County, Wisconsin. All individuals in the county are funded on the basis of self-determination principles, part of which means they control their service dollars and have the say over their services and support. As the county has implemented and continues to expand its realization of the principles of self-determination, it has also instituted choice of case manager. Six private agencies provide case management, and there are three case management provider fairs each year for individuals to meet case managers and make a choice. The county recommends that consumers and their families meet at least three different case managers before making a choice. Consumers indicate that having a choice of case manager is one of the most important features to them about their support structure, even more important than how large a services allocation they receive.

In addition, over the years in which self-determination was being instituted, several individuals wanted to have a family relative or friend be their case manager. In order to honor this choice, a seventh agency was established to provide the administrative support for these individuals who

were not licensed case managers. This agency and the county play key roles in monitoring the support provided by family relatives or friends who are functioning as case managers.

The county retains the functions of screening, eligibility determination, and allocation of service dollars, and county case managers have increased their role in quality assurance. In addition, a small number of complex cases are retained on county caseloads. Safeguards are in place if individuals seem to be abusing the system by changing case managers too often.

Several Minnesota counties have already greatly increased their use of private case management agencies, but the Dane County model should be studied more closely for strategies to increase meaningful choice among case managers.

### **Phase-in strategies for Minnesota**

In many counties, there would have to be several stages of phase-in to expand choice from the current publicly based system to include private providers. It is likely that implementation would be more rapid in the metro and other urban areas than in more rural areas. It should also be noted that both in Dane County, Wisconsin, and in one Minnesota county that has been significantly increasing its use of private contracted case management, no county employee positions have been lost.

Some minimum standards of qualifications and competency would need to be set for private case managers, although no state has to date been able to implement a fully competency-based certification process for case managers. Similar standards for qualifications and the same performance standards could be used for private providers as are currently used for county case managers or for flexible case managers. If structures are established to allow family members and/or friends to be an individual's case manager, it is likely that different qualification standards would need to be considered.

The first phase of implementation should be establishing what is needed in business process designs to provide for increased contracting with private providers. In some rural parts of Minnesota, private entities may not emerge to provide case management; development of new networks could be encouraged and could be carefully crafted inside a detailed county- or state-administered RFP process. As the number of private agencies expands, assuring meaningful choice by consumers will need to be addressed. As a last step of this phase, family control of services and funding should be available for consumers and families who want this role, and such control should be available regardless of which funding stream or waiver is used. Safeguards would need to be in place at each of these steps, to accommodate too much "shopping around" as well as to assure oversight of the effectiveness of family members or friends who are fulfilling a case management role.

Other concerns which would need to be addressed include:

- assuring quality, consistency and continuity
- training and knowledge base of all county and private case managers
- access to information on management information systems for all county and private case management providers

In a second phase, consumer choice could be enhanced by private agencies participating in an open enrollment process, directly contracting with the state. This alternative is explained in Recommendation #5 below.

Shifting to a non-public service coordination system (alongside a public gatekeeping system) probably would be best accomplished as an evolutionary process wherein the proportion of case management furnished by non-county vendors grows over time. At some future date, Minnesota could consider establishing a benchmark for the mix of county and non-county case management and encourage counties that fall below the benchmark to step up their use of contracted case management.

### **Implementation Recommendation**

Initially, it is recommended that the state work with a stakeholder workgroup to establish reasonable timelines and structures for gradual implementation and systemic shift. This group could also be used to develop the RFP process, determine core competencies and create training, and address such questions as maintaining quality and whether special standards should be required for specific disability populations.

### **Potential Costs**

The experience in shifting a greater share of case management to non-county providers has been that counties are able to purchase case management at lower rates than when case management is furnished by county employees. At the same time, some counties report offsets to these savings in the form of increased utilization (increased volume of billings per person) and additional county administrative expenses in overseeing and supporting non-county providers, especially with respect to ensuring that the providers are well versed in procedures and requirements. Over time, as the non-county case management provider community matures, these additional expenses should diminish.

During the first phase when counties are encouraged to expand their use of non-county providers, the most circumspect approach would appear to be to assume that the near term expenditure impact would be neutral. That is, lower direct case management costs may be offset by additional costs that counties may incur in overseeing and supporting non-county providers; these costs should be accommodated through Medicaid administrative claiming (see Recommendation #5 below). Counties report that these costs are not currently accommodated.

There should also be minimal implementation costs, since many of the counties today already have the billing mechanisms in place. State billing and reimbursement systems also already accommodate non-county providers.

During a later phase of open enrollment (described below in Recommendation #5), as the role that non-county providers play in furnishing case management expands further, the per-person cost of case management can be expected to decline. The exact extent of decline will hinge on the extent of the shift from county to non-county case management. Conservatively, each shift

of 10% of the case management caseload from counties to non-county providers should translate into a reduction of 2% in per-person costs across the entire caseload.

#### **RECOMMENDATION #4. REGIONALIZE SOME FUNCTIONS**

Regionalizing some county administrative functions could result in overall cost savings, streamline some processes, and assist counties in addressing some current case management challenges. Several specific county administrative functions were mentioned by county staff in this project, all of which affect how case management is carried out. The functions which were most frequently mentioned for regionalizing are:

##### **1. Contracting With and Licensing of Providers**

Some rural counties have limited administrative capacity for these functions, which limits quality and can discourage new providers. In the metro area, numerous counties contract with the same provider agencies, so one agency contract across several counties would simplify the process for both the counties and the providers. The contracting process could be streamlined across several counties or there could be a statewide contracting effort. In addition, contracting with private case management agencies (Recommendation #3 above) could be regionalized.

##### **2. Management of Waiver “Slot” Allocations**

The number of allocated waiver “slots” could be managed on a regional basis, rather than by individual counties, especially in smaller counties in greater Minnesota.

##### **3. Quality Assurance**

Most counties wish to do more quality assurance and monitoring, but have limited capacity to do so. In a separate report to the legislature ([www.qapanel.org](http://www.qapanel.org)), the Minnesota Quality Assurance Panel has made specific proposals for quality assurance, including Regional Quality Councils. Stakeholder focus groups in the case management project being discussed in this report recommended that such councils be pursued.

Stakeholders also made comments on the benefits of regionalizing case management and social services functions, whether or not regional quality councils are established. The potential benefits of regionalizing mentioned by stakeholders include:

- Time and money saved where counties are currently duplicating efforts
- Improved relationships with providers
- Improved monitoring of providers who serve in multiple counties
- Resources could be pooled for scarce services (medical, dental, psychiatry, mental health, crisis supports)
- Training could be pooled for county staff, providers, consumers and families
- Common contracting language used across counties
- Increased uniformity in measurement, licensing, and oversight



## **Establishing Regionalized Contracting Entities**

In Minnesota, case management is furnished through 84 distinct county entities (some of Minnesota's 87 counties have consolidated operations). Across these entities, there is wide variation in the number of individuals who receive case management. The counties with consolidated operations for social services (Lincoln-Lyon-Murray and Faribault-Martin counties) report advantages in reduction of overall administrative costs and pooling of knowledge and specialization across counties.

From a business perspective, consolidation of case management operations among the counties would be likely to improve efficiency, especially with respect to gatekeeping functions and administrative overhead costs. Reducing the number of counties with which the state has to negotiate and do business for human services can simplify and reduce duplicative costs in administration and improve services.

However, for service coordination functions, regionalization in more rural areas will probably not contribute to improved efficiency in performance because of geographic distance factors. While certain administrative functions can be managed on a regionalized basis, ongoing service coordination should be provided more locally. It would be important to retain local knowledge of resources and services for these service coordination functions. For example, a centralized regional office could be maintained for administrative functions, while local offices could be maintained for service coordination. This concern would likely not be an issue in the metro area.

To implement this change, one important issue to address would be county attorneys' concerns for liability protection and joint powers. These concerns could be addressed in several ways, including new policies regarding individual county liability, a state pool to address possible suits, assessing the methodology in current joint county arrangements, or other approaches.

## **Cost Proposal**

The state should encourage regionalization by inviting counties to propose how they would consolidate operations, and by providing funding to support the development of consolidation plans and covering one-time regionalization costs. It would be difficult to estimate the overall financial impact of regionalization of case management at this time, since it would be dependent on such factors as size of each region, etc. Local county proposals could address estimates of costs and savings in a particular group of counties. Regionalization would be facilitated by state assumption of county case management costs (see Recommendation #6 below).

As a starting proposition, it is recommended that \$500,000 be earmarked to support the development of consolidation plans and awarded to groups of counties through an RFP process. Consolidation plans should identify both the one-time costs of consolidation and expected offsetting cost-savings over an appropriate time horizon (e.g., five years). When a plan demonstrates that one-time costs can be recovered within the specified time-horizon, the state should make a grant to cover those costs. These grant funds would be recovered (in the form of lower payments to the counties) over the consolidation plan time horizon. Going forward, should this initial effort to support consolidation planning prove successful, it could be replicated in subsequent years.

## **RECOMMENDATION #5. SIMPLIFY MEDICAID FINANCING OF CASE MANAGEMENT**

Minnesota's current methods of financing case management are complex. There are many complaints about how requirements for case managers to track time/activity erode the time that they have to perform "real" case management in support of people with disabilities. Although this complaint is not unique to Minnesota, it is legitimate to ask whether Minnesota can simplify financing. There are two main pathways available for Minnesota to restructure Medicaid financing. Before a discussion of these pathways, a brief summary is included on dimensions of federal policy that affect Medicaid financing of case management.

### **FEDERAL POLICY DIMENSIONS**

Federal policy provides for two basic methods for a state to secure federal Medicaid dollars to underwrite case management. These methods are:

- 1. Service Claiming.** A state may furnish case management as a Medicaid service by covering case management as an HCBS waiver service and/or by covering case management as a TCM service under its Medicaid State plan. When *service claiming* is employed, the services that are claimed for federal financial participation must be documented as to the Medicaid beneficiary for whom the service was provided. This documentation may take the form of recording the time that a case manager expends performing an allowable activity on behalf of a person or recording an allowable activity (e.g., a face-to-face visit) that triggers a Medicaid payment. As previously discussed, Minnesota employs both methods. Regardless of the method that is employed, service claiming revolves around the activities performed on behalf of each specific Medicaid beneficiary. Service claiming is beneficiary-centered. Payments may be structured to recoup case manager salaries, support and supervisory costs, and the administrative overhead that is attributable to the provision of the service. Federal policies impose some restrictions on the types of case management activities that may be claimed as services, depending on how a state covers case management in its Medicaid program. For example, certain activities associated with enrollment of a person to an HCBS waiver may not be claimed as a service expense under the waiver. In the case of TCM, activities such as prior authorization and eligibility determination are not considered eligible activities.
- 2. Administrative Claiming.** Medicaid administrative claiming is available for the costs that a state incurs to operate its Medicaid program. Many case management activities can be claimed as an administrative expense. There is overlap between the types of activities that can be claimed as administrative expenses or claimed as a Medicaid service. For example, the development of a service plan or monitoring its implementation can be covered as a Medicaid service or claimed administratively.<sup>13</sup> Administrative claiming methods are different from service claiming methods. As a general matter, an administrative claim is documented by performing a time study to properly attribute personnel and other allowable costs to Medicaid-related activities (especially in the case of public entities) or is based on a contractor's charges for furnishing case management. Administrative claiming is not directly

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<sup>13</sup> A state may not, of course, claim the same costs both ways.

beneficiary-based; instead, it revolves around the costs that are attributable to performing an activity that is necessary for the operation of the Medicaid program.

While there is crossover between service and administrative claiming with respect to the types of case management activities that a state may claim, there are some activities that may only be claimed as a service (principally, activities associated with connecting Medicaid beneficiaries to non-Medicaid services, e.g., connecting individuals to local housing programs). In some states, the rate of federal financial participation in the costs of Medicaid services is higher than the rate that applies to administrative expenses. In Minnesota, the two claiming rates are the same (50% of allowable costs). However, in the past, Minnesota's claiming rate for services has been higher than the administrative claiming rate.

Broadly, either service claiming or administrative claiming will yield about the same amount of federal Medicaid dollars for case management, especially in a publicly managed system such as Minnesota's. However, there are some differences in the types of activities that may be claimed under either method.

There is another dimension of federal policy that can affect a state's selection of a Medicaid claiming method for case management. When case management is claimed as a service, states are generally required to ensure that Medicaid beneficiaries can freely select from among qualified case management providers. Moreover, a state must permit all willing and qualified providers to enroll as Medicaid providers. This requirement applies when case management is furnished as a waiver service. In the case of TCM, federal law permits a state to restrict the providers of case management for people with developmental disabilities (and persons who have a mental illness) to public entities such as counties. Otherwise, open provider enrollment requirements apply to TCM. When administrative claiming is employed, a state may restrict the providers of case management, including selecting providers through an RFP process.

This federal policy dimension has implications for aligning Medicaid financing with a state's case management delivery platform. For example, for case management for people with developmental disabilities, some states (e.g., Colorado) have selected the TCM coverage option in order to align Medicaid coverage/claiming to the state's statutory requirement that limits the provision of case management to single point of entry community agencies.

In order to continue to align the financing of case management to its county-managed service delivery platform, recently Minnesota had to obtain an additional federal waiver in order to continue to limit the delivery of TBI Waiver case management services to counties.<sup>14</sup> Going forward, Minnesota faces the prospect of having to secure similar additional waivers for the CAC, CADI and MR/RC Waiver programs in order to continue to match claiming with the county delivery platform.

## **ALTERNATIVE MEDICAID CASE MANAGEMENT FINANCING PATHWAYS**

Reduced to its simplest terms, Minnesota has a single platform (the counties) for the delivery of case management to people with disabilities but, in order to capture federal Medicaid dollars, multiple funding streams are used with their attendant complications and burdens. While

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<sup>14</sup> Specifically, Minnesota had to secure federal approval of a waiver under the provisions of §1915(b)(4) of the Social Security Act in order to maintain the *status quo* with respect to TBI Waiver case management. Under this provision of the Social Security Act, a state may request a federal waiver to limit the entities that may furnish a Medicaid service. Securing this waiver delayed the renewal of the TBI Waiver.

simplifying case management financing is possible, changing funding streams has various ramifications. Here, two options for simplifying Medicaid financing are presented. Both options are discussed in the context of Minnesota’s maintaining its present county-managed case management delivery platform.

In its 2005 report to the Minnesota Legislature concerning case management,<sup>15</sup> DHS properly noted that case management can be conceptualized as composed of two main functions: direct *service coordination* that is performed on behalf of an individual Medicaid beneficiary (e.g., preparing a service plan on behalf of a person and monitoring the delivery of services) and “*gatekeeping*” activities (e.g., service plan authorization and eligibility determination). This framework is useful in exploring options for potentially simplifying the financing of case management in Minnesota.

### **Option 1. Consolidate Services Claiming Under TCM**

Minnesota currently uses both federal *services claiming* options (HCBS waiver and TCM) to underwrite case management. As previously noted, there is little difference in the scope of *service coordination* activities that may be claimed under either of these options. The differences between these options lie in the coverage of gatekeeping/administrative types of activities (TCM does not permit the coverage of such activities while, under a waiver, some gatekeeping/administrative functions may be covered. For example, under TCM, activities associated with the review and approval of a service plan may not be covered while under a waiver, they may be.) In terms of basic service coordination activities, there is little difference between the two options.

As a consequence, one strategy that Minnesota can entertain – which DHS raised in its 2005 report – is to drop the coverage of case management from the waivers and exclusively use the TCM option to cover service coordination functions. Gatekeeping and other administrative functions could be consolidated under administrative claiming and performed through the counties as is presently the case (through the SSTS). In Minnesota, there is no difference in the rate of federal financial participation between services claiming and administrative claiming (the rate is 50% for both). There would be a negligible effect on federal revenues from dropping the coverage of case management from the waivers, shifting to the TCM coverage, and consolidating gate-keeping and other administrative costs under administrative claiming.

Under the federal TCM coverage option, states have latitude in specifying the groups of Medicaid beneficiaries who may receive TCM. Many states use the TCM option to furnish case management to HCBS waiver participants rather than covering case management as a waiver service. In our view, Minnesota could fashion TCM coverages to align with the present scope of coverage (i.e., the coverages could be fashioned to avoid a net increase in caseload by limiting the coverages to persons who participate in a waiver or are in the present TCM target group). For example, it may be feasible for Minnesota to wrap its current coverages into two TCM coverages:

- One coverage that would span MR/RC Waiver participants and people who receive VA-DD/TCM. This distinct coverage could wrap around the Rule 185 mandate (but would not cover

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<sup>15</sup> Department of Human Services (2005). *Case Management for Persons with Disabilities: A Status Update on Reform Efforts and Preliminary Findings to the Legislature.*

the case management costs for persons with MR/RC who receive Intermediate Care Facility for Persons with Mental Retardation/Related Conditions (ICF/MR) services.

- A second coverage that would wrap around people with other disabilities, including CAC/CADI/TBI Waiver participants and potentially home care TCM beneficiaries.

The potential advantages in exclusively employing the TCM coverage are:

- **Standardizing Payment/Documentation across Medicaid Beneficiaries.** A single method could be used to establish payment rates and billing/claiming rather than the present practice of requiring time-based claiming for HCBS waiver case management and activity-based claiming for VA-DD/TCM. Documentation requirements could be standardized.
- **Standardizing the Scope of Case Management.** The scope of service coordination activities could be standardized. Similarly, a uniform framework could be used to claim county gatekeeping and administrative costs.

There are some potential issues/cautions associated with changing over to TCM *services claiming* exclusively. In particular:

- **Changing CMS Policy.** CMS is increasingly forcing states to employ 15-minute billing units in conjunction with the delivery of TCM. Should CMS dictate that Minnesota adopts 15-minute billings units, switching over to TCM service claiming would not relieve case managers from having to record time in 15-minute units as is the case under the HCBS waivers.
- **Chasing Dollars.** In the past, stakeholders have expressed reservations about switching to TCM because the present billing method incentivizes case managers to perform at least one activity every month in order for the county secure the case management payment. In other words, chasing dollars distorts the provision of case management. This is a legitimate concern. When an activity is not performed, the case management provider does not realize revenue. This problem is observed in other states where a monthly payment is made for case management. The problem stems from Medicaid service claiming requirements – namely, in order for a provider to make a claim for payment, a documented service/activity must have been performed during the billing period. Much the same problem, however, can attach to time-based billing systems. Time-based billing, however, sometimes permits billing to align more closely with the flow of case management activities on behalf of individuals. Billed units can flex with the intensity of case management performed on behalf of each person. However, time-based billing can be more burdensome for case managers.

When service claiming is employed, a state is forced to choose between one billing/claiming method and the other. Each method has its pros and cons. A third alternative – paying for service coordination on a “per member per month” (PMPM) basis theoretically would offer a way to avoid some of the problems associated with the two principal billing/claiming methods.<sup>16</sup> However, securing CMS approval for such an approach could prove challenging.

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<sup>16</sup> Under such an approach, a standard payment for case management would be made each month per Medicaid beneficiary but would be divorced from the performance of an activity on behalf of each beneficiary each month. This type of “capitated” payment would parallel payment approaches used for managed care arrangements. However, we are unaware of any state that presently uses this method for payments for case management services under the Medicaid State plan. Such a method would not relieve case managers from recording time and/or activities since a PMPM approach would require accumulating encounter-type data. The chief advantage of a

- **Alteration of HCBS Waiver Allocations.** Switching HCBS waiver case management to TCM potentially would require altering waiver allocation funding formulas. This might prove complex in its own right.
- **Matching Funds.** The state provides the matching funds for HCBS waiver case management while counties generally provide the matching dollars for TCM. Shifting exclusively to TCM raises the question of whether to continue the present matching fund arrangement or shift entirely to state matching. This topic is discussed separately below.

In our view, adopting TCM as Minnesota’s single avenue for services claiming offers some potential for simplifying the financing of case management. It is consistent with the service coordination/gate-keeping framework that DHS articulated in the 2005 report. However, consolidating financing under TCM will still require person-by-person documentation of case management activities.

### **Option 2. Switch Exclusively to Administrative Claiming**

The second option that Minnesota can entertain is to drop services claiming altogether in favor of exclusively employing *administrative claiming* for case management. As a general matter, administrative claiming can be employed to obtain federal Medicaid financing of nearly all essential case management functions (whether gate-keeping or service coordination). However, administrative claiming may not be used to pay for case management activities/functions that revolve around connecting people to non-Medicaid services/programs.

Exchanging services claiming for administrative claiming would relieve case managers of a good deal of the burden associated with the present time/activity tracking requirements now in play. Periodic time studies and/or payments to contractors can be used to establish the basis of the claim. Administrative claiming also could aid in avoiding some of the issues associated with chasing dollars when services claiming is used. Administrative claiming also aligns well with Minnesota’s present public case management delivery platform. Since there is no difference in the rates of federal payment for administrative and service claiming in Minnesota, shifting exclusively to administrative claiming would not lead in and of itself to a loss of federal Medicaid dollars. Administrative claiming also would help Minnesota avoid having to seek additional §1915(b)(4) waivers to align financing with the current county-based case management delivery platform.

As previously noted, the state of Washington uses administrative claiming exclusively to underwrite the costs of case management that is furnished to seniors and people with disabilities. In Washington, all case management functions are performed by state employees. Colorado also uses administrative claiming to underwrite the costs of its Single Point of Entry (SPOE) agencies through which individuals are evaluated and enrolled in the state’s HCBS waiver for older persons and persons with disabilities. The SPOE agencies perform gatekeeping and service coordination functions under contract with the state Medicaid agency.

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PMPM approach is that it would flow funds to counties in a steady stream and relieve counties from having to bill on a beneficiary basis. In our view, preparing and successfully negotiating a PMPM approach with CMS would require considerable time and effort.

Wrapping around county-provided case management through administrative claiming would potentially simplify county operations and state management of financing. However, there are potential drawbacks/issues associated with employing administrative claiming:

- As previously noted, there are some service coordination activities that are not eligible for federal Medicaid payment under administrative claiming. Principally, such activities are those that involve connecting individuals to non-Medicaid benefits. The basis of administrative claiming is that it is limited to activities that are necessary to the proper and efficient administration of the Medicaid program. When a case management activity involves connecting people to non-Medicaid services, alternative funding would be required. However, at least with respect to people who participate in a HCBS waiver, a waiver coverage could potentially be added to cover such “community connector” activities.
- Administrative claiming most comfortably aligns with the present county-based case management delivery platform. While a state in theory could contract with multiple case management networks to afford individuals greater choice of case management provider under administrative claiming, this rarely occurs. If the objective in Minnesota is to give individuals a wider range of choices in terms of case management providers, service claiming is the more appropriate financing architecture.
- Wrapping all case management under administrative claiming also raises the issue of whether the state or counties provide the necessary matching funds. In addition, shifting HCBS waiver case management to administrative claiming would necessitate modifying the present HCBS funding allocation schemes.

In some respects, administrative claiming is a simpler (but still not entirely simple) method of securing federal Medicaid dollars for case management. Under administrative claiming, Minnesota would have the ability to establish financial controls over the amount expended for case management. In our view, administrative claiming aligns well with Minnesota’s present county-managed case management delivery platform.

## **SUMMARY OF FUNDING RECOMMENDATIONS -- IMPLEMENTATION**

Medicaid case management financing involves selecting from an imperfect set of federal options. Administrative claiming emerges as potentially the most efficient option for Minnesota to simplify the securing of federal Medicaid dollars to underwrite the present county case management delivery platform - that is, continuing to center the delivery of case management around the counties and county-selected contractors.

However, service claiming (such as under TCM), especially for service coordination functions, is the better option when a state is interested in broadening the providers of case management. When service claiming is coupled with open enrollment of providers (agencies contracting directly with the state as a service coordination agency, rather than the county as an intermediary), individuals and families will have more choices in the selection of service coordination providers and more authority to change service coordinators.

In its 2005 report to the Legislature, DHS raised the potential of consolidating federal Medicaid funding through the TCM option for the service coordination elements of case management with

counties retaining gatekeeping and other management responsibilities. We recommend that Minnesota adopt this framework with an end goal of shifting to open enrollment of qualified service coordination providers under TCM. This change should be implemented in two stages.

The first stage will entail crafting TCM coverages to replace the current MR/RC, CAC, CADI, and TBI Waiver coverages. Crafting these coverages will provide Minnesota the opportunity to ensure consistency in the scope of required/allowable service coordination activities furnished on behalf of people with disabilities. Concurrently, other modifications will be necessary to support the claiming of Medicaid administrative funding for county gatekeeping functions, including functions related to county oversight of non-county service coordination providers. The current structure wherein counties serve as the primary providers of case management would be retained and counties would continue to contract with non-county providers as is presently the case. Counties should be encouraged to increase their use of non-county providers. If necessary, Minnesota should seek a federal 1915(b)(4) waiver in order to continue the present case management service delivery platform during this stage.

In the second stage, Minnesota would implement open enrollment of service coordination providers. Individuals and families would be able to freely select from among all qualified service coordination providers, including county service coordinators. This stage would continue to entail the use of both TCM and administrative claiming. Open enrollment allows the system to move toward more of a market orientation, control costs, and support more rigorous monitoring of minimum performance standards such as number of visits. Mechanisms would need to be established to control overuse, such as under the TCM monthly rate methodology. Again, counties would retain gatekeeping and other management responsibilities. The state could contract directly with case management (service coordination) provider agencies, or there could be a three-party contract including the county.

## **COSTS**

These recommended changes will require time to accomplish, since state and local accounting and billing systems will need to be changed. A new claims payment system or infrastructure would not be necessary, but some modifications would be required. Consolidating Medicaid financing of case management under a TCM/administrative claiming architecture will require some changes in state and county IT systems. Principally, these changes will impact administrative claiming with respect to ensuring that the full range of claimable administrative costs are identified and properly attributed to Medicaid. This likely will require modifying SSTS and its algorithms for attributing time to federal programs. Particular attention should be paid to accounting for administrative costs that counties have identified as associated with case management but are not captured in present systems. If the state commits to pursuing this option, further analysis would be required to develop an estimate of these modification costs, as well as training costs. In addition, any information system redesign should take into account how the system would interface with claims generation.



## **RECOMMENDATION #6. STANDARDIZE CASELOAD SIZES**

Standardizing caseload sizes would be a significant challenge, but it has significant ramifications. The costs involved in setting standard caseload sizes would be at least partially dependent on whether changes in funding streams described above were pursued.

Minnesota affords counties considerable latitude in organizing and managing the delivery of case management. Each county may decide how many case managers it directly employs, the extent to which case management is provided by county employees or is contracted out to non-county vendors, and whether case managers specialize by population group. Counties exercise control over how many dollars are budgeted for case management. DHS reviews county operations to determine whether the county has performed case management in accordance with state rules and regulations.

Not surprisingly, there is considerable variance across the counties in their level of effort in furnishing case management to people with disabilities within the broad framework of state policy. Evidence of this variance includes:

- A 2005 Disability Services Division survey of counties found that the average caseload of MR/RC case managers was 52.8 individuals. Across counties, however, caseloads ranged from a low of 20 to a high of 100.<sup>17</sup>
- Another measure of case management level of effort is the number of units of HCBS waiver case management delivered and billed per waiver participant. In-depth analysis of county-by-county billings for HCBS waiver case management reveals significant differences in number of units delivered per participant per year across the waivers. For example, in 2005, on average each MR/RC Waiver participant received 79 units of case management (about 20 hours for the year). However, the number of units furnished by counties ranged from a low of 30 units per participant to a high of 168 units per participant. This result is not surprising in light of the wide variance in case manager caseloads across the counties. A similar pattern of a high degree of county-by-county variance in case management level of effort is observed when billings for CAC, CADI, and TBI Waiver case management services are examined. The variation in the number of units billed/paid, of course, translates into equally wide differences in the payments for case management, county-by-county.
- As previously noted, payment rates for VA-DD/TCM vary considerably county-to-county. Since these rates are based on county level of effort, the wide variance in the rates is indicative of variance in underlying case management delivery.

In any large system, a certain amount of variance in level of effort at the point of delivery is not unusual. Individuals differ in the extent of case management support that they require.

However, the observed variance in Minnesota is surprisingly wide.

Variance in level of effort means that people in some counties receive appreciably less case management support than people in other counties. While individuals may need different levels of case management support, one would not expect to observe wide inter-county variance. Basic

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<sup>17</sup> Department of Human Services (2006). Disability Services Division MR/RC Case Management Survey January 1 through December 31, 2005. Accessed at: [dhs.state.mn.us/dhs\\_id\\_059933.pdf](http://dhs.state.mn.us/dhs_id_059933.pdf).

case management delivery requirements would predict that the level of effort would be roughly comparable, on average, county-to-county.

One way that states ensure a uniform system-wide level of case management services is to specify a caseload standard. That is, providers of case management are expected to maintain sufficient staffing so that case manager caseloads do not exceed the state specified level. For example, in its state-managed case management delivery system for people with developmental disabilities, Connecticut specifies a caseload standard of 45 persons per case manager. The specification of a caseload standard means that individuals have access to the same general level of case management support locality-to-locality.

Minnesota has not overlaid a uniform case management caseload standard on counties. In part, this has been due to reservations that a uniform standard would prove to be too rigid. In addition, because counties bear financial responsibility for the delivery of some types of case management, imposing a uniform standard could cause some counties to have to increase spending for case management (and, in the alternative, might lead to some counties reducing case management level of effort – a uniform standard can cut both ways).

At the same time, absent a caseload standard, it can be very difficult to ensure that people with disabilities have access to at least a baseline level of case management support county-to-county. A caseload standard can serve as a useful benchmark, especially in supporting assurance of the adequacy of case management funding and the efficiency of case management delivery. Such analysis demands a point of departure. A caseload standard also can serve as the basis for determining an appropriate payment rate for case management.

Having a standard will also assist in determining caseload sizes when coordination of care is complex, such as when certain individuals require a great deal of coordination between the continuing care system and basic health care systems. For individuals with high care coordination needs and other specialty populations, special rates or contracts could be established.

Some states have “tiered” case management by the amount of support needed by individuals on the caseload. The amount of support needed is not necessarily dependent on an individual’s capacities – for example, often people with higher capabilities need more intense support. The system needs to be flexible in providing different amounts of support as crises occur and as needs change. It is also often more effective for individual case managers to have a caseload with individuals of varying abilities. In actual practice, many Minnesota counties already are informally implementing a “tiered” system – providing more and less amounts of case management support depending on the person, but more formally determining broad case management support parameters for numbers and types of individuals can also be taken into account in determining caseload size.

In terms of recommending that Minnesota adopt a specific caseload standard, we note that at least with respect to MR/RC case management, at 52.8 individuals per case manager, Minnesota’s 2005 caseload was appreciably above the nationwide norm of 40 individuals per

case manager<sup>18</sup>. The difference was approximately 25%. Only eleven (generally smaller) Minnesota counties had caseloads at or below the nationwide average. Many of Minnesota's larger counties have caseloads that are well above the nation-wide norm. The relatively high case loads that case managers are carrying explains why they spend a large proportion of their time dealing with crisis cases. In order for case managers to devote more time to individuals, their present caseloads need to be reduced. However, achieving the nationwide caseload norm would be an expensive proposition, as explained below, and will involve addressing county costs for case management.

## **STATE ASSUMPTION OF CASE MANAGEMENT FUNDING**

In Minnesota, counties underwrite the costs of case management. Medicaid financing is used to offset county costs by the pass-through of federal Medicaid dollars to the counties. The state contributes matching funds in the case of HCBS waiver case management and RSC/TCM. Counties also shoulder the costs of Rule 185 and other case management that cannot be recouped through Medicaid (e.g., case management costs associated with individuals who are ineligible for Medicaid).

This mixed financing arrangement (i.e., state funding for some types of case management but not for other types) potentially distorts local decision-making concerning the allocation of dollars for case management. When counties are responsible for underwriting case management exclusively out of their own funds, they will be reluctant to increase their level of effort. This can cause them to keep staffing levels low or increase contracting out case management, since contracted case management is generally less costly than furnishing case management through county staff. With respect to state-funded case management, increasing case management level of effort competes with funding direct services within the overall county waiver allocation. In addition, counties will come out short if the payment rate for waiver case management does not fully compensate their costs. Excess costs spill over into county funding in one fashion or another.

When counties have responsibility for funding case management, they understandably will resist state efforts to standardize level of case management effort (i.e., standardized caseload sizes) or impose performance standards or benchmarks when the result is increased costs. This will especially be the case when payment rates do not adjust quickly enough to compensate counties for their increased costs.

For Minnesota to move toward more standardized case management delivery, serious consideration should be given to the state's buying out the county share of case management costs. A state buy-out would permit standardizing case management payments and, thereby, enable standardizing case management delivery across the state.

Buying out the county share of Medicaid-funded case management services would cost approximately \$17 million based on 2005 billings reported by DHS. Spanning across all case

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<sup>18</sup> Robin Cooper (2006). *Medicaid and Case Management for People with Developmental Disabilities: Options, Practices, and Issues (Revised)*. Alexandria VA: National Association of State Directors of Developmental Disabilities Services.

management and related costs (including costs that are outside Medicaid) would boost this estimate substantially.

## **COSTS FOR STANDARDIZING CASELOADS**

If Minnesota moved to standardizing caseloads, and used a 1:40 ratio, as is the national average for persons with developmental disabilities, it would require an estimated additional \$8.2 million in state funds for establishing this standard for persons receiving support under the four Medicaid waivers.

Making an estimate of these costs is difficult, however, since there is only caseload information (both in Minnesota and nationally) available for MR/RC Waiver and not the other program areas. Based on billings, CADI Waiver caseloads seem to be higher than MR/RC Waiver caseloads, and TBI and CAC Waiver caseloads seem to be lower. However, for purposes of the cost estimations proposed here, the same standard was applied to all groups.

Based on the 2005 DHS caseload study, MR/RC Wavier case managers have an average caseload of 52.8 individuals. In 2005, the average expenditure for MR/RC Waiver case management was \$1,688 per participant. Therefore, the total expenditure per case manager associated with the 1:52.8 caseload was \$89,126 (52.8 individuals times \$1,688). Reducing the average caseload to 40 individuals per case manager translates into an expenditure per participant of \$2,228 (\$89,126/40) or 32.0% above the 2005 average cost.

The cost of extending the 1:40 caseload standard to the other HCBS waivers may be calculated as the difference between 2005 per waiver participant expenditures for each waiver and the \$2,228 benchmark cost associated with a 1:40 caseload. This calculation is shown in the following table:

**Table 1: Cost of 1:40 caseload standard for four Medicaid waiver programs**

<b>Waiver</b>	<b>2005 Case Management Cost Per Participant</b>	<b>Current Caseload</b>	<b>Benchmark Cost</b>	<b>Difference</b>	<b>Number of Waiver Participants</b>	<b>Additional Amount Necessary to Implement 1:40 Caseload</b>
<b>MR/RC</b>	\$1,688	52.8	\$2,228	\$540	14,803	\$7,993,620
<b>TBI</b>	\$2,022	44.1*	\$2,228	\$206	1,295	\$266,770
<b>CADI</b>	\$1,412	63.1*	\$2,228	\$816	9,892	\$8,071,872
<b>CAC</b>	\$2,292	38.9*	\$2,228	(\$64)	240	N/A
<b>Total</b>						\$16,332,262
<b>State</b>						\$8,166,131
<b>Federal</b>						\$8,166,131
* Estimate. This estimate is derived by dividing the MR/RC Waiver total expenditure per case manager (\$89,126) by the 2005 case management cost per participant for these waivers.						

Implementing a 1:40 caseload standard across all four waivers would have a total federal/state Medicaid cost of \$16.3 million and require an additional \$8.2 million in state matching funds, based on the number of waiver participants in 2005. These amounts would have to be adjusted to take into account growth in the number of waiver participants between 2005 and the present. The amount also would need to be adjusted to reflect rate increases/cost of living adjustments since 2005. Lower case manager caseloads, of course, could be phased-in over a multi-year period.

Extending the 1:40 caseload standard to VA-DD/TCM would have a total cost of \$1,847,940, one half of which would be federal. These costs are shown in the following two tables, with and without state buy-out of the county share (as explained above).

**Table 2: Establishing 1:40 ratio including four Medicaid waivers, VA-DD/TCM included, and no state buy-out of the county share.**

<b>Funding Stream</b>	<b>2005 Case Management Cost Per Participant</b>	<b>Current Caseload</b>	<b>Benchmark Cost</b>	<b>Difference</b>	<b>Number of Individuals</b>	<b>Additional Amount Necessary to Implement 1:40 Caseload</b>
<b>MR/RC</b>	\$1,688	52.8	\$2,228	\$540	14,803	\$7,993,620
<b>TBI</b>	\$2,022	44.1*	\$2,228	\$206	1,295	\$266,770
<b>CADI</b>	\$1,412	63.1*	\$2,228	\$816	9,892	\$8,071,872
<b>CAC</b>	\$2,292	38.9*	\$2,228	(\$64)	240	N/A
<b>VA-DD/TCM</b>	\$1,848	48.2*	\$2,228	380	4,863	\$1,847,940
<b>Total</b>						\$18,180,202
<b>State</b>						\$8,166,131
<b>County</b>						\$923,970
<b>Federal</b>						\$9,090,101
* Estimate. This estimate is derived by dividing the MR/RC Waiver total expenditure per case manager (\$89,126) by the 2005 case management cost per participant for these waivers.						

**Table 3: Establishing 1:40 ratio including four Medicaid waivers, VA-DD/TCM included and including state buy-out of the county share.**

<b>Funding Stream</b>	<b>2005 Case Management Cost Per Participant</b>	<b>Current Caseload</b>	<b>Benchmark Cost</b>	<b>Difference</b>	<b>Number of Individuals</b>	<b>Additional Amount Necessary to Implement 1:40 Caseload</b>
<b>MR/RC</b>	\$1,688	52.8	\$2,228	\$540	14,803	\$7,993,620
<b>TBI</b>	\$2,022	44.1*	\$2,228	\$206	1,295	\$266,770
<b>CADI</b>	\$1,412	63.1*	\$2,228	\$816	9,892	\$8,071,872
<b>CAC</b>	\$2,292	38.9*	\$2,228	(\$64)	240	N/A
<b>VA-DD/TCM</b>	\$1,848	48.2*	\$2,228	380	4,863	\$1,847,940
<b>Total</b>						\$18,180,202
<b>State</b>						\$9,090,101
<b>Federal</b>						\$9,090,101
* Estimate. This estimate is derived by dividing the MR/RC Waiver total expenditure per case manager (\$89,126) by the 2005 case management cost per participant for these waivers.						

[Note: these estimates are solely based on the costs reported in the Continuing Care Matrix. They may be underestimates, especially with respect to county case management that falls outside of what is captured in the care matrix.]

### **Implementation Recommendations**

Going forward, Minnesota should move toward adopting a caseload standard benchmark. The state will then be better able to gauge where it stands with respect to the funding of case management, and what it will take to boost the funding that will be required to implement the benchmark. DHS should consider adopting a multi-year strategy of progressively increasing funding to improve case manager caseloads. Additional issues concerning setting a caseload standard are discussed above in the section concerning State Assumption of Case Management Funding.

In addition, going forward, counties should be required to annually report their case manager workloads for each waiver and other programs so that DHS has updated information regarding this important metric.

A sample of steps which could be taken include:

1. Legislature authorizes a certain amount of funds to boost case management funding, for example, by 15%, and earmarks these dollars for caseload reduction.
2. Counties annually report caseloads across all populations (including accounting for contracted case management).
3. State sets the benchmark at 40 across all populations and, based on reported caseloads in step 2, incrementally moves toward the benchmark.

## **IX. ADDITIONAL RECOMMENDATIONS**

This project gathered a significant amount of information from major stakeholder groups concerning recommendations for change and improvement. The recommendations gathered from interviewing 19 counties were validated in the stakeholder survey process (Appendices B and E). That is, there is a high level of agreement on which areas need improvement. In addition, prior to receiving surveys with recommendations gained from county interviews, focus group participants were asked, in open-ended questions, to provide their own suggestions for improvement. These areas also had a high degree of correspondence with the recommendations from the county interviews.

Besides the six major recommendations presented in the previous section, the additional recommendations for improvement collected in the county interviews and the stakeholder focus group meetings are briefly described here. We recommend that DHS pursue these directions, some of which are already underway but need to be continued and expanded.

### **AREAS ALREADY BEING PURSUED BY DHS**

DHS indicated that there are already efforts underway to pursue three areas of concern to stakeholders:

#### **A. Quality Assurance**

It was recommended that DHS provide more assistance with quality assurance to counties, including:

1. Provide methods and support (e.g., checklists for monitoring services across all service groups, support in monitoring provider quality).
2. More person-centered quality assurance processes (such as the Region X “VOICE” process).

A separate report to the Legislature has provided major recommendations for expanded quality assurance in the state ([www.qapanel.org](http://www.qapanel.org)). As part of this case management project, stakeholders were asked for their recommendations concerning one element of expanded quality assurance efforts, establishing regional quality councils. Stakeholders were in favor of this proposal, and saw many benefits of such councils. Stakeholders recommended that these quality councils be composed of many different types of stakeholders and that they be vested with the authority to carry out their mandated activities.

#### **B. Clarify Some Elements in Consumer-Directed Community Supports**

Some elements of CDCS are currently confusing for consumers, such as the question of what are they really purchasing if they use their services funds to purchase case management. DHS is currently at work on adjusting the allocation process and other refinements of this program.

## **C. Managed Care Recommendations**

There were two major areas of recommendation concerning managed care programs:

1. Reduce the level of bureaucracy.

Different managed care companies use different forms, which are different than the state-required forms.

2. Ensure that processes follow a more person-centered (rather than medical) model.

Current managed care pilot programs are under-way which can address these concerns.

## **OTHER STAKEHOLDER RECOMMENDATIONS**

The following three areas were also recommended by stakeholders, and can be incorporated into other efforts.

### **A. Support Creativity**

1. Encourage more creativity and options.
2. Increase/identify resources to counties for development of new service options that allow consumers more real choices, including more housing options and new services.

### **B. Address the New Freedom Initiative in regard to Nursing Home Use**

1. Develop improved systems for diverting people from nursing home admissions and into community options.
2. Develop more systems for moving people out of nursing homes, especially those under age 65, if desired .

(Note: The Minnesota State Council on Disability has submitted a report to the Legislature on this issue.)

### **C. Improve Elements in Flexible Case Management Option in CDCS**

1. Clarify and/or reassure counties of their capacity to intervene when there are problems or concerns.
2. Enhance the certification and training for flexible case managers.

## **LONGER RANGE DIRECTIONS**

Two directions from other states would have larger system implications for services for people with disabilities in Minnesota. These two longer-range directions were highly rated by



stakeholders and should be kept in mind as the system moves forward into the future.

### **A. Determining Individual Allocations and Support for Creative Options**

Every innovative model from other states that was based on self-determination utilized a model of completing a comprehensive assessment of a person's situation, including support needs and adequacy of support network, and then designating an individualized support allocation. In all these innovative models, there is an extensive system of support brokers and facilitators of circles of support to assist the individual and/or their family to design the best and most personally tailored support situation possible with the individual allocation. Two such examples are New Jersey's Real Life Choices program ([www.fscnj.org/rlcprovover](http://www.fscnj.org/rlcprovover)) and England's in Control Project ([www.in-control.org.uk](http://www.in-control.org.uk)). Instituting such a method in Minnesota would affect many complex elements of the system, but was the most highly rated reform effort of the innovative models from other states which were presented at the stakeholder focus groups. It is worth referencing as the system moves toward increased self-determination and consumer control.

Wyoming has initiated an Individual Resource Allocation model called DOORS, which has been recognized by CMS as a "promising practice." DOORS is a well-researched, studied formula for determining an individual's service allocation based on participant characteristics and service utilization patterns. It places a premium on fairness and equitability, improves equity of resources within and between populations, and supports the free choice of provider. Also, because Wyoming is a state-administered system, an individual's funding is portable and easily moves with them to different providers, service types, and parts of the state. More information is available at [www.cms.gov/promisingpractices](http://www.cms.gov/promisingpractices). Again, this is a longer-range direction which would be worth pursuing in the future.

### **B. County-Administered Managed Care**

Some states are developing managed care models for services for people with disabilities, and there are several managed care pilots underway in Minnesota for these groups. If the state expanded utilization of managed care, it would be worthwhile to include the option of county-administered managed care. Wisconsin is currently piloting such an option in its Family Care program ([www.dhfs.state.wi.us/lcicare](http://www.dhfs.state.wi.us/lcicare); [www.dhfs.state.wi.us/managedLTC](http://www.dhfs.state.wi.us/managedLTC)). Minnesota's South Country Health Alliance is a county-administered nine-county managed care program, but Wisconsin's program is more extensive, pooling all funding streams.

## **SUMMARY OF RECOMMENDATIONS TO IMPROVE EFFICIENCY**

As a general matter, Minnesota's per person case management costs fall within ranges observed in other states. Average per person costs vary across Minnesota's HCBS waivers. The TBI and CAC Waivers have higher per person costs than the MR/RC and CADI Waivers. This result is what one would expect programmatically, given the nature of each waiver's service populations.

Still, it is legitimate to ask whether there are ways that the efficiency of case management can be improved. There are potentially four ways for improving the efficiency of case management:

- 1. Regionalization** – discussed above in Recommendation #4.
- 2. Contracting Out Service Coordination** – discussed above in Recommendation #3.
- 3. Information Technology** – discussed above in Recommendation #1.B.
- 4. Cross-County Case Management** – In Minnesota, counties retain case management responsibility for their residents who move to another county. Sometimes counties are able to make arrangements for the county to which the person has moved to assume case management responsibilities. However, in other cases, the originating county case manager must travel to the other county. This can be a costly proposition and a source of inefficiency. Minnesota should provide for the transfer of case management responsibilities from the originating to the receiving county. We acknowledge that providing for such transfers can pose financial and logistical complications. However, it makes more sense for the receiving county to assume responsibility than for originating counties to attempt to perform case management from a distance.

## **X. CONCLUSION:**

### **SUMMARY OF RECOMMENDATIONS AND IMPLEMENTATION STRATEGIES**

A significant concern by many stakeholders is that changes should not be imposed by the Department of Human Services without significant and continuing stakeholder involvement in planning and implementation. Any new models and reforms should only be developed with on-going input from and in collaboration with different stakeholder workgroups of county personnel, consumers and their representatives, advocacy organizations, provider agencies, and other stakeholders.

Development of the Comprehensive Assessment process over the last few years provides an excellent example of stakeholder involvement and ownership in a DHS initiative. We recommend that pursuit of each of the recommendations in this project similarly proceed with significant involvement of various stakeholder workgroups to refine specific practices, policies, and implementation procedures.

### **SUMMARY OF KEY RECOMMENDATIONS**

These key recommendations are also summarized in Table 4 at the end of this section.

#### **1.A. Streamline and standardize processes.**

Continue the work on streamlining and standardizing processes such as the Comprehensive Assessment process. Proceed and expand the work on other avenues for standardizing and streamlining processes, such as the universal plan and a common service menu across waivers.

### **1.B. Establish a well-coordinated management information system.**

Invest in an up-to-date, well-coordinated management information/information technology system. Research the systems in other states which may be able to be adapted to Minnesota at much lower cost than original design work.

### **2.A. Standardize performance measures.**

Standardize performance measures, such as timelines for required activities, across service categories, funding streams, and disability groups.

### **2.B. Individualize performance measures.**

Determine which performance measures can be adapted to use individually-designed measures as the performance standard to be monitored.

### **3. Expand consumer choice of case manager.**

Expand opportunities for increasing consumer choice of case manager, through:

- increasing private case management for service coordination
- assuring that county administrative, gate-keeping and quality assurance functions are adequately funded
- assuring no conflict of interest with agencies providing direct support to an individual
- designing and integrating opportunities for meaningful consumer choice

### **4. Regionalize some county administrative functions.**

Encourage regionalization by inviting counties to propose how they would consolidate operations, and provide funding to support the development of consolidation plans and to cover one-time regionalization costs. Regionalization should especially be encouraged for licensing, contracting, allocation of waiver slots, and quality assurance.

### **5. Simplify Medicaid financing by utilizing a combination of TCM/administrative billing.**

Minnesota should adopt the framework of consolidating federal Medicaid funding through the administrative billing plus TCM option for the service coordination elements of case management, with counties retaining gatekeeping and other administrative and quality assurance responsibilities. In a second stage, Minnesota should shift to open enrollment of qualified service coordination providers under TCM.

### **6. Move toward standardizing caseload sizes.**

Establish an initial allocation, such as 15% of case management dollars, to begin to reduce caseloads. Establish a system for ongoing reporting of caseload sizes, for both county and

private providers, for all disability groups, to determine a reasonable benchmark for caseload size. Use this reporting to incrementally move toward an established benchmark.

Besides these areas, additional and supplementary recommendations are included above in Section IX.

### **SUMMARY OF COSTS FOR KEY RECOMMENDATIONS**

1. Estimated \$2 million to \$3 million for management information system.
2. Recommendation to allocate 1% of total case management expenditure for training and quality improvement.
3. Increasing private case management for service coordination should be cost-neutral and potentially less costly per-person in the long-term.
4. Earmark \$500,000 for RFP process for counties to make regionalization proposals.
5. Simplifying funding to TCM/administrative billing combination itself should be cost-neutral, but will require some modifications in database and billing systems which will require additional study to determine costs.
6. Estimated cost to standardize caseload size for people on four Medicaid waivers: \$8.2 million.

Additionally, state assumption of case-management funding (county buyout) for four waivers: \$17 million.

Although additional initial expenditures will be required for an effective management information system, such a system will result in future cost savings in use of case manager time and should greatly improve performance and efficiency. Each of the reform recommendations will have a fiscal impact, which will need to be monitored and managed. Significant system and case management effectiveness, efficiency and improvement in performance are all intrinsically tied to caseload size, adequacy of management information systems, and consumer choice of case manager.

**TABLE 4: SUMMARY OF KEY RECOMMENDATIONS FOR CASE MANAGEMENT REFORM**

Proposed Reform	Current System	Potential Benefits of Reform	Challenges of Reform	Costs of Reform	Recommended Implementation
<p>1. Standardize and simplify processes</p> <p>A. Universal processes such as assessment, service menu, etc.</p> <p>B. Coordinated Database</p>	<ul style="list-style-type: none"> <li>• Programs have different rules, forms, processes</li> <li>• Inequities between programs</li> <li>• Multiple technological systems for financial and program data; use varies by County</li> <li>• In some cases, complex first point of entry and service navigation</li> </ul>	<ul style="list-style-type: none"> <li>• Improve equity across processes for all groups</li> <li>• Streamline all processes</li> <li>• Improve access to and quality of service coordination</li> <li>• Technological improvements (database) support recommendations 2-6</li> <li>• Improve all business practices</li> </ul>	<ul style="list-style-type: none"> <li>• Training County and other personnel</li> <li>• Implementation of new technology</li> </ul>	<p>MIS Technology costs:</p> <ul style="list-style-type: none"> <li>• Other states have developed from scratch for \$20 to \$50 million</li> <li>• Options to purchase existing systems – estimated \$2 to \$3 million</li> </ul>	<ul style="list-style-type: none"> <li>• DHS is implementing many items currently</li> <li>• Technology and database systems should be pursued as soon as possible</li> <li>• This reform supports all other reforms recommended</li> <li>• Tie to current Quality System Architecture initiative</li> </ul>
<p>2. Standardize performance measures and maximize individualization</p>	<ul style="list-style-type: none"> <li>• Standards vary between waivers, and other programs</li> <li>• Consumers and case managers report required visits are often too much or too little for individuals</li> <li>• Quality improvement difficult to track</li> </ul>	<ul style="list-style-type: none"> <li>• Standardize to improve equity</li> <li>• Individualization of processes increases consumer-control and flexibility</li> <li>• More quality improvement efforts between counties and DHS becomes possible</li> </ul>	<ul style="list-style-type: none"> <li>• Rule changes may be needed</li> <li>• Technology system in reform #1.B. will affect efficiency and equity here</li> <li>• Standardization across programs may increase workload</li> <li>• Training county and other personnel</li> </ul>	<p>Ongoing technical assistance:</p> <ul style="list-style-type: none"> <li>• Proposed 1% of total Case Management expenditure used for training and quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Particularly among waivers, prompt implementation of standardized measures recommended</li> <li>• Develop workgroups to address individualized standards</li> </ul>

<p>3. Provide choice of case manager</p>	<ul style="list-style-type: none"> <li>• Counties choosing to contract for case management; families not allowed to choose provider</li> <li>3. Gatekeeper and service/ advocacy functions by the same entity; possible conflict</li> <li>• Families and advocates desire greater choice</li> </ul>	<ul style="list-style-type: none"> <li>• Strongly preferred by consumers</li> <li>• CMS increasingly requiring consumer choice of case management provider for waiver approval</li> <li>• Separation of administrative and service functions</li> <li>• County maintains gatekeeping functions and increases quality assurance role</li> </ul>	<ul style="list-style-type: none"> <li>• Separates service and administrative functions</li> <li>• Training stakeholders</li> <li>• Managing conflicts of interest</li> <li>• Creating sustainable markets, particularly in rural areas</li> <li>• Safeguards needed for consistency and to limit “shopping around”</li> <li>• Ensuring meaningful consumer choice among providers</li> </ul>	<ul style="list-style-type: none"> <li>• Overall costs anticipated to be neutral</li> <li>• Per-person private case management is less expensive</li> <li>• A neutral effect short term, due to county monitoring and training costs. Per-person costs should decrease in the long-term.</li> </ul>	<p>County retains gate-keeping and quality assurance functions</p> <p>Contracting out service coordination only</p> <p>Establish limits on providers to ensure no conflict of interest</p> <p><i>Tiered implementation:</i></p> <p><i>Phase 1: Step A:</i></p> <p>Establishing business designs and building the market through RFPs and increase in choice through the county.</p> <p><i>Step B:</i></p> <p>Implementing meaningful consumer choice of vendor</p> <p><i>Step C:</i> Option for families/friends to become the case management entity</p> <p><i>Phase 2:</i> Open enrollment for service coordination agencies</p>
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<p>4. Regionalize some county functions</p>	<ul style="list-style-type: none"> <li>• State contracts with 84 county entities</li> <li>• Counties duplicating efforts. For example, most in a region contract with the same providers individually</li> <li>• Current joint county arrangements are working well</li> </ul>	<ul style="list-style-type: none"> <li>• Likely cost savings</li> <li>• Streamlines processes across counties</li> <li>• Assists counties with identified challenges</li> <li>• Administrative cost and burden reduced for state, counties and providers</li> <li>• Could increase quality assurance efforts</li> </ul>	<ul style="list-style-type: none"> <li>• Resolving possible turf issues</li> <li>• Distance challenges in rural areas</li> <li>• County attorney concerns for liability protection and joint powers</li> <li>• Streamlining policies across counties</li> </ul>	<ul style="list-style-type: none"> <li>• Earmark \$500,000 to begin development through RFP process</li> <li>• Counties could identify potential savings in their proposals</li> </ul>	<ul style="list-style-type: none"> <li>• Establish an RFP process with groups of counties</li> <li>• Proposals identify both one-time costs of consolidation and expected long term savings</li> <li>• If long-term savings demonstrated, grants could be replicated</li> <li>• Retain local service coordination</li> </ul>
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<p>5. Simplify funding</p> <ul style="list-style-type: none"> <li>To combination of TCM and Administrative Billing</li> </ul>	<ul style="list-style-type: none"> <li>Overly cumbersome reporting and billing system (service claiming with TCM and waiver services; plus administrative cost recovery)</li> <li>Variation between counties in tracking and funding case management</li> <li>Administrative burden to track time, taking away from direct client contact</li> <li>Often the funding complexity results in “chasing dollars”</li> </ul>	<ul style="list-style-type: none"> <li>Simplifies funding and reporting</li> <li>Use of TCM: <ul style="list-style-type: none"> <li>Standardizes documentation, payment, and scope of service across MA beneficiaries</li> </ul> </li> <li>Administrative claiming: <ul style="list-style-type: none"> <li>Relieves the burden of time/activity tracking</li> </ul> </li> <li>Simplifies operations <ul style="list-style-type: none"> <li>Allows funding for county gate-keeping function</li> </ul> </li> <li>Aligns with the county-based delivery model</li> <li>Can establish controls over amounts expended for case management</li> </ul>	<p>Recommended mix of TCM/administrative claiming:</p> <ul style="list-style-type: none"> <li>Requires documentation to recover dollars</li> <li>May require altering waiver funding formulas and matching funds arrangements</li> <li>Can result in “chasing dollars”</li> </ul>	<ul style="list-style-type: none"> <li>Equal funding is anticipated</li> <li>Change can be established within current billing systems; some modifications will be needed</li> <li>Costs associated with Recommendation #1 to implement database changes can improve efficiency</li> <li>Changes to this system can occur as the supporting technology (Recommendation #1) gets developed.</li> </ul>	<p>Multiple stages:</p> <p><i>Phase 1:</i> Crafting TCM coverage to replace the current MR/RC, CAC, CADL, and TBI HCBS waiver coverage; other modifications to support the claiming of Medicaid administrative funding for county gate-keeping functions.</p> <p><i>Phase 2:</i> Roll out TCM functions to private entities (open enrollment); counties primarily retain administrative claiming functions .</p>
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<p>6. Standardize caseload size</p>	<ul style="list-style-type: none"> <li>• Average size caseloads are higher than national averages</li> <li>• High variability in case management caseloads and effort across counties and populations</li> <li>• Case Managers report unmanageable caseloads</li> <li>• Large amounts of “crisis management” and lack of proactive care and planning</li> </ul>	<ul style="list-style-type: none"> <li>• Equalizes level of effort among counties</li> <li>• Provides assurance of a baseline level of support</li> <li>• Reduces time spent on crises</li> <li>• Pro-active care possible</li> <li>• Supports analysis of rate structures</li> <li>• May reduce Case Manager burn-out</li> </ul>	<ul style="list-style-type: none"> <li>• Mandating standards could affect county expenditures</li> <li>• Special rates or contracts may be needed for those with complex needs</li> <li>• Expensive to move Minnesota to the national standard</li> </ul>	<ul style="list-style-type: none"> <li>• In short term, allocate an amount such as 15% of total case management dollars to begin to reduce caseloads.</li> <li>• Estimated amount to standardize caseloads for 4 waivers (to reduce to national standards): 8.2 million</li> </ul>	<ul style="list-style-type: none"> <li>• Allocation of a 15% increase to be applied to reducing caseloads</li> <li>• Require ongoing reporting of caseload sizes, both county and private providers, for all disability groups</li> <li>• Monitor and continue to increase funding to move as close as possible to the national standard (40 per caseload)</li> </ul>
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**APPENDIX A**  
**INTERVIEW FORMAT – MINNESOTA COUNTIES**

**REDESIGN OF CASE MANAGEMENT SERVICES IN MINNESOTA**  
**Minnesota Key Informant Phone Interview Protocol**  
**Spring 2006**

1. *For case managers:* Please describe your current caseload (e.g., size, disability type). How do you think case management services differ across disability types? *For county social service supervisors:* Please describe your case managers' current caseloads (e.g., size, disability type). What is the number of case managers supervised for each supervisor, and the level of supervision? How do case management services differ across disability groups / waiver programs?
2. How do you define case management services for \_\_\_\_\_ (specify disability group/waiver group)? How does the definition differ for different disability/waiver groups? How do your policies, procedures, practices coincide with your definition of case management?

We are gathering information about current practices and policies regarding case management for all people under age 65 with physical, cognitive, and chronic health conditions determined to have a disability, including:

- people with developmental disabilities who meet the definition of mental retardation or related condition
- people under age 65 using PCA services
- people under age 65 using home care services with a disability determination
- people with traumatic or acquired brain injury
- people with physical disabilities or chronic medical condition
- people on CAC, CADI, TBI, MR/RC waivers
- people in nursing facilities under age 65

3. Please describe your case management system, **for each of the populations you serve,** including your policies and procedures in the following areas:
  - ⇒ eligibility determination
  - ⇒ assessment criteria and processes
  - ⇒ screening
  - ⇒ service authorization
  - ⇒ plan development
  - ⇒ assisting in accessing services/selecting providers
  - ⇒ coordination of services
  - ⇒ evaluating and monitoring of direct service provision
  - ⇒ annual review of the plan
  - ⇒ review of eligibility
  - ⇒ conciliations and appeals
  - ⇒ resource allocation across disability groups, waivers, and other funding streams (if any, please describe).

**PROBE:** You described your case management system for each of the groups you serve in the above areas; can you describe the system for any other group? If not, who should I talk to about the other groups?

**PROBE:** How is case management being implemented across different disability groups and waiver programs (CAC, CADI, MR/RC, TBI) in actual practice?

4. Thinking about your CURRENT CASE MANAGEMENT SYSTEM, please answer the following questions. **[Note that these questions are about the case management process.]**
- a. How are case management services evaluated and monitored in your county? Please describe. Do you evaluate the performance of these administrative and service functions the same way for each disability/waiver group? Is there any consumer evaluation of case management?
  - b. Please describe your quality assurance and protection processes. Does this differ for each disability/waiver group? How could they be improved?
  - c. In your current case management system, are you using outside vendors FOR CASE MANAGEMENT? If so, what functions do they serve (what do they do)? Do you use public and/or private vendors? What differs in policies or procedures for outside case management vendors compared to county case managers? What are the strengths/weaknesses of using these vendors?
  - d. If you use outside vendors for case management, what are your *financial models for payment*? How does the authorization of services work? How are the contracts for services approved?
  - e. What are your *business process designs for outside case managers*? Please describe how you reimburse your contracted case management providers. How do you budget and track the use of these services throughout the year?
  - f. What kinds of technological support does your county have for case management (e.g., case managers have laptops, what databases do you use)?

**PROBE:** Is what you described the same across the different populations of interest (see bulleted list in question #2)? If not, can you please describe the differences? If not, who else should I speak with?

5. Do you have any model practices that may be applied to only one disability group in practice but that could be generalized to other groups as well? If so, please describe.
6. Are you familiar with the managed care models used in your county, for elderly or other groups? What are the benefits/drawbacks to using a managed care model of case management as opposed to the traditional case management model? Please describe any best practices.
7. Do you also provide case management in child protection? If so, do you know if there are any relevant, applicable, or useful procedures and policies in child welfare case management practices that would be useful for consideration for disability groups?

8. Are you familiar with Flexible Case Management under CDCS? Have you functioned as a Flexible Case Manager or worked with one? What are the benefits/drawbacks and best practices related to using this model?
9. Please identify any additional strengths / best practices in your county's current case management system. Please identify any additional weaknesses in your county's current case management system.  
How do you feel about the number of contacts required, and how caseloads are managed?
10. **IF TIME, ASK FOR RECOMMENDATIONS:** Please provide recommendations for improving Minnesota's current case management system (and feel free to offer innovative ideas).

**APPENDIX B**  
**COUNTY SURVEYS**

Recommendations were developed from interviews of 19 Minnesota counties. Surveys were administered at stakeholder focus group meetings in September 2006 to determine stakeholder agreement with county-generated recommendations. A separate survey was administered to direct consumers.

*FROM COUNTY INTERVIEWS RECOMMENDATIONS FOR IMPROVING CURRENT SYSTEM*

**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neither Agree nor Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
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**A. Standardize, simplify and equalize processes across all disability groups and 4 waivers**

1. Streamline processes -- one plan, one release of information, universal standard of service, comprehensive (universal) assessment –for all groups of people with disabilities.

1	2	3	4	5
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2. Consistency across all four waivers for resource allocation/universal way to set benefits

1	2	3	4	5
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3. Common menu of services across all 4 waivers

1	2	3	4	5
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4. Improve assessment process for people receiving Personal Care Assistance

1	2	3	4	5
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**B. Improve county capacity for quality assurance**

5. More assistance from DHS to counties on how to do quality assurance (for example, DHS provide a checklist for monitoring services across all service groups; DHS provide direction on methods to monitor providers)

1	2	3	4	5
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**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

**Strongly Disagree**   **Disagree**   **Neither Agree nor Disagree**   **Agree**   **Strongly Agree**

6. More person-centered monitoring processes 1                      2                      3                      4                      5

**C. 7. Set standard for caseload size (based on different levels of support needed)** (If you agree, what should the caseload size be? \_\_\_\_\_) 1                      2                      3                      4                      5

**D. Allow as much individualization as possible based on a person’s need**

8. Waive some rules if people don’t need it (e.g., number of required visits) 1                      2                      3                      4                      5

9. Separate people needing high, medium, low amounts of support and provide appropriate amount of support in each group. (Stop requiring case management for people who don’t need it; prioritize the limited resources available, especially to those with highest need) 1                      2                      3                      4                      5

**E. Encourage more creativity and resource development**

10. Encourage more creativity and more options 1                      2                      3                      4                      5

11. Provide more resources to counties to develop options so consumers can actually have more choices, such as more housing options, new service development 1                      2                      3                      4                      5

**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neither Agree nor Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
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12. Address the problem that small counties have limited capacity to facilitate contracts and license new providers (for example, have one contracting process across several counties or a statewide effort, etc.)

1	2	3	4	5
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**F. Improve business practices**

13. Have databases that are more useable (such as MMIS reports being more helpful and useful)

1	2	3	4	5
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14. Improve information systems so all information flows better and more comprehensively (for example, from assessment to plan to monitoring, etc.)

1	2	3	4	5
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15. Simplify the time-study process for case managers

1	2	3	4	5
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16. State provide more assistance to counties with issues such as rate setting and new business practices

1	2	3	4	5
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17. Have assessment process on-line which people can complete themselves

1	2	3	4	5
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**G.**

**18. Develop more systems for diverting people from nursing home admission to community options and for moving people under age 65 out of nursing homes**

1	2	3	4	5
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**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

**H. Consumer Directed Community Supports**

- |  | Strongly<br>Disagree | Disagree | Neither<br>Agree nor<br>Disagree | Agree | Strongly<br>Agree |
|--|----------------------|----------|----------------------------------|-------|-------------------|
| 19. Clarify case management purchases for people receiving CDCS  | 1                    | 2        | 3                                | 4     | 5                 |
| 20. With flexible case management: assure county's capacity to intervene when there are problems; enhance certification and training | 1                    | 2        | 3                                | 4     | 5                 |

**I. With private managed care companies:**

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 21. Reduce the level of bureaucracy – different agencies use different forms, which are different than state required form | 1 | 2 | 3 | 4 | 5 |
| 22. Ensure that processes follow a more person-centered model  | 1 | 2 | 3 | 4 | 5 |

**23. OTHER (what other recommendation do YOU have)**

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**I AM A:**

- \_\_\_\_\_ consumer/self-advocate
- \_\_\_\_\_ family member
- \_\_\_\_\_ county case manager
- \_\_\_\_\_ county case manager supervisor
- \_\_\_\_\_ other county staff \_\_\_\_\_
- \_\_\_\_\_ other case manager (private contracted, flexible, etc.)
- \_\_\_\_\_ residential services provider
- \_\_\_\_\_ day program/employment provider
- \_\_\_\_\_ other \_\_\_\_\_

## *CONSUMER PREFERENCES*

### **WOULD YOU BE INTERESTED?**

**Yes**   **No**

1. on-line computer assessment of your own needs  
\_\_\_\_
2. you say how much case management you want or need  
\_\_\_\_
3. your choice among many case managers  
\_\_\_\_
4. if case management was not with county but with a private company  
\_\_\_\_
5. know amount of money for your services first, then figure out what services to get  
\_\_\_\_
6. more help with figuring out how to use your services money to find a job or place to live  
\_\_\_\_
7. keeping people with disabilities out of nursing homes  
\_\_\_\_
8. get people out who are in nursing homes now  
\_\_\_\_
9. more checking on quality of what you get -- someone checking on you or other people more often  
\_\_\_\_

**APPENDIX C**  
**INTERVIEW FORMAT –**  
**MODELS AND INNOVATIONS IN OTHER STATES**

Information was gathered on 20 states that had been either been recommended for different case management structures or for innovations in case management.

**REDESIGN OF CASE MANAGEMENT SERVICES IN MINNESOTA**  
**State Key Informant Phone Interview Protocol**  
**Summer 2006**

***Interview Questions***

For your information, we are gathering information about current practices and policies regarding case management for all people under age 65 with physical, cognitive, and chronic health conditions determined to have a disability, including:

- people with developmental disabilities who meet the definition of mental retardation or related condition
  - people under age 65 using PCA services (**NOTE: different states may use a different term for PCA**)
  - people under age 65 using home care services with a disability determination
  - people with traumatic or acquired brain injury
  - people with physical disabilities or chronic medical condition
  - people on CAC, CADI, TBI, MR/RC waivers (**NOTE: different states may use different terms for these waiver programs**)
  - people in nursing facilities under age 65
1. Please describe your current case management system. How do you go about providing case management (i.e., how is case management being implemented)? Does this differ across different disability groups and waiver programs? Please identify strengths and weaknesses of your current case management system. What are the implications of this system for various groups of stakeholders, such as consumers, case managers, providers (the strengths and weaknesses for these various stakeholder groups)?
  2. How do you define case management services for \_\_\_\_\_ (specify disability group/waiver group)? How does the definition differ for different disability/waiver groups?
  3. What is your governance structure (e.g., possible configurations include county-based, purely privatized, public but state-based, non-profit local authorities, case managers work for independent providers and consumer choose, and so forth)? Please describe how the structure works. Please identify strengths and weaknesses of your current case management governance structure. What are the implications of this structure for various groups of stakeholders, such as consumers, case managers, providers? What are the cost implications of this structure?
  4. What are the average caseloads for case managers? Again, does this differ across different disability groups and waiver programs? What is the typical/average number of case managers per supervisor? PROBE: Do you use support/service brokers? If so, what is their average caseload size?
  5. Have you changed your case management structure/model/processes in recent years (e.g., gone to universal screening, gone to managed care that's county run or run by private agencies, gone to contracted case management for service coordination, do budget

allocations before plan of care, etc.)? If so, can you please tell us what prompted the change and how it's working (strengths, weaknesses of the change; lessons learned; implications for various groups of stakeholders, such as case managers, consumers, providers; cost implications)?

6. What are the strengths and weaknesses in your current case management system? (Possible areas of discussion include):
  - hidden costs / cost implications
  - impact on different stakeholder groups (consumers, case managers, providers)
  - implementation implications across disability groups
  - implementation challenges for both public and private vendors
  - implementation barriers across different waiver and other funding streams
7. For anyone hoping to change/improve their current case management system, do you have any recommendations/innovative ideas for doing this?
8. How is your case management process for persons with disabilities under age 65 tied to nursing home admissions and demissions? Is there any intervention to divert people who face nursing home placement to community-based alternatives?
9. Is your state using managed care models for case management? What are the benefits/drawbacks to using a managed care model of case management as opposed to the traditional case management model? Please describe.
10. Do you have any model practices that may be applied to only one disability group in practice but that could be generalized to other groups as well?
11. Are you aware of any innovative case management practices currently occurring in your state (other than what has been discussed)? If so, can you please provide us with a name and phone number of someone we could contact regarding that innovative practice?
12. Do you know of any innovative case management practices currently occurring in any other state? Do you know who we should contact?

**Thank you for taking your time to speak with us about case management in your state.**

## **APPENDIX D**

### **SURVEY OF OPTIONS FROM OTHER STATES**

Reform models were developed from interviews in other states of innovative models and other state structures. Surveys were administered in September 2006 stakeholder focus groups.



*WHAT ARE OTHER STATES DOING?  
POSSIBLE DIRECTIONS FOR LARGER SYSTEM CHANGES*

**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
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1. IMPROVED SYSTEMS COORDINATION ACROSS ALL GROUPS (including improved information technology)	1	2	3	4	5
<hr/>					
<hr/>					
<hr/>					

2. WITH EVERYONE) ALLOCATION PROCESS BASED ON ASSESSMENT OF NEED AND CURRENT SUPPORTS	1	2	3	4	5
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**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

Strongly Disagree    Disagree    Neither Agree nor Disagree    Agree    Strongly Agree

3. (DIFFERENT STRUCTURES FOR CONSUMER-DIRECTED SUPPORT PROGRAMS)    1    2    3    4    5

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4. TIERED LEVELS OF CASE MANAGEMENT SUPPORT (e.g., New Jersey)    1    2    3    4    5

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5. INCREASE PRIVATE CASE MANAGERS    1    2    3    4    5

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**I THINK THIS IDEA IS WORTH PURSUING IN MINNESOTA**

Strongly Disagree    Disagree    2    Neither Agree nor Disagree    3    Agree    4    Strongly Agree    5

6. COUNTY-ADMINISTERED MANAGED CARE    1    2    3    4    5

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. PRIVATELY-ADMINISTERED MANAGED CARE    1    2    3    4    5

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I AM A:**

- \_\_\_\_\_ consumer/self-advocate
- \_\_\_\_\_ family member
- \_\_\_\_\_ county case manager supervisor
- \_\_\_\_\_ other county staff
- \_\_\_\_\_ other case manager (private contracted, flexible, etc.)
- \_\_\_\_\_ residential services provider
- \_\_\_\_\_ day program/employment provider
- \_\_\_\_\_ other: \_\_\_\_\_

**APPENDIX E**

**SEPTEMBER 2006 INPUT OF STAKEHOLDER FOCUS GROUP PARTICIPANTS**

## September 2006 Input of Stakeholder Focus Group Participants

### A. METHODOLOGY

Two rounds of focus groups in four communities, a total of eight meetings, were conducted to gather information from a variety of stakeholders interested in Minnesota's current and future approach to case management.

The first set of focus groups in September 2006 collected a wide variety of information from stakeholders. First, participants were asked what they liked about the current system and what suggestions for improvement they had before any information gathered from previous parts of the project were presented. The purpose of these questions was to gather information and ideas from a new group of stakeholders as they came into the meetings and to give them an opportunity to express any concerns they had, before they were asked for their input concerning any proposed reforms.

Altogether, four forms of information were collected:

1. Open-ended questions about what people liked about current case management practices.
2. Open-ended questions about what people thought should be changed or improved.
3. A survey with 22 recommendations gathered from the telephone and face-to-face interviews which had been conducted with key informants in 19 Minnesota counties regarding recommendations for change (Appendix B). Those interviews were documented and the themes that emerged from those discussions were used to create this survey administered to focus group participants.
4. A survey concerning information collected on innovations in other states (Appendix D). Information from twenty other states had been collected regarding innovative models. This survey listed seven different approaches to case management and services system reform being used in other states. Participants were asked to score these ideas in terms of their potential usefulness for Minnesota.

In addition, an adapted version of the county survey form was developed for direct consumers. This survey only contained questions directly relevant to consumers and excluded questions about county administration (Appendix B). There were too few direct consumers who attended focus groups for analysis of their responses.

Background information about the project was provided to participants about each of the survey items in #3 and #4, prior to the surveys being administered.

### FOCUS GROUP PARTICIPANTS

A total of 277 people participated in the first round of eight focus groups held throughout Minnesota. The number of participants per group was:

- New Ulm
  - September 7, 6:30 p.m.: 10 people
  - September 8, 10:00 a.m.: 28 people

- St. Cloud
  - September 14, 4:00 p.m.: 26 people
- Duluth
  - September 19, 11:30 a.m.: 21 people
  - September 19, 6:00 p.m.: 10 people
- Twin Cities
  - September 21, 9:00 am.: 128 people
  - September 21, 1:30 p.m.: 38 people
  - September 21, 6:30 p.m.: 16 people

On the survey forms, focus group participants described the roles they had in the current case management system. Table A1 shows the proportion of respondents who reported being in each stakeholder group. The question allowed multiple responses (for example, a person may have been both a parent and a case manager). The most common affiliation of focus group participants was county case manager (45% of all participants). This is as expected, since the focus groups were advertised through the key contacts in the 19 counties in which interviews were conducted. Other stakeholders that were represented by at least 10% of the participants included family member (16%), county case management supervisor (14%), and residential service provider (12%). Fewer than 10% of the respondents reported that they were a day program or employment provider, in some other county role, a case manager for a private organization, or a consumer or self-advocate. Overall, 63% of all participants worked for county governmental agencies, 48% worked in a case management role, and 17% were either a consumer or a family member. Across all respondents, 15% mentioned that they were in more than one of the listed roles.

For the purposes of analysis, each participant was assigned to one role. Because some participants reported more than one role, a hierarchy was established that determined in which role those persons would be counted for analysis purposes. People who reported that they were either a family member or a self-advocate were placed into that category regardless of the other roles they reported they represented. A total of 17% of the respondents were classified as family members or self-advocates. Those respondents who were neither family members nor self-advocates were then classified as case managers if they reported that as one of their roles (44% of the total respondents were categorized into that group). Of the remaining participants, those who worked for county government organizations were grouped into the third category (18% of the total). The final group represented everyone else. Most members of that group worked for a provider organization, but advocacy organization representatives, state staff, and other stakeholder groups not otherwise categorized were also included in that group. There were 17 people who declined to provide role information. For analyses that compared responses between different groups, those respondents were excluded.

**Table A1: Responses by Group and Role Assignments**

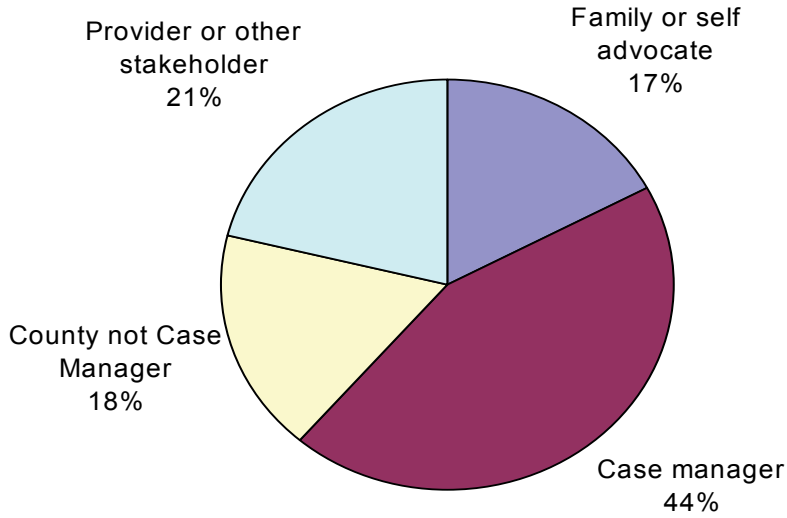
<b>Reported Roles (Could report multiple roles)</b>	<b>Percent</b>
County case manager	45%
Other	16%
Family member	16%
County supervisor or other	14%
Residential service provider	12%

Day program or employment provider	6%	
County other	6%	
Case manager other (private contracted, flexible, etc)	4%	
Consumer/self-advocate	2%	
<b>Summary Roles</b>		
Works for a county	63%	
Case manager county or other	48%	
Consumer or family member	17%	
Mentioned more than one role	15%	
<b>Assigned Role for Analysis (Assigned Hierarchically)</b>	<b>Percent</b>	<b>N</b>
1. Family or self advocate	17%	39
2. Case manager	44%	101
3. County not Case Manager	18%	40
4. Provider or other stakeholder	21%	48
Total with role information		228
Missing role information		17
Total surveys		245

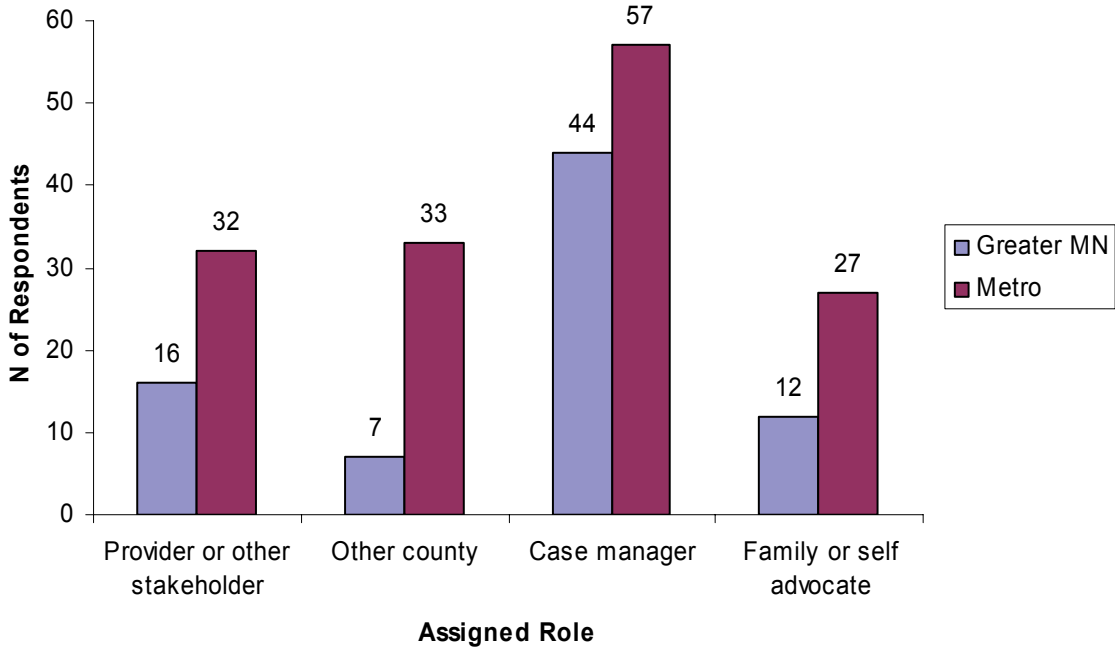
Respondents were assigned to the highest numbered group to which they reported belonging.

Figure A1 shows the proportion of participants who provided role information who were classified into each of the combined groups. For purposes of comparing responses in different regions of the state, each participant was also classified into one of two regional groups: either as participating in a “metro area” focus group or as participating in one of the three focus groups that were conducted in “greater Minnesota.” Of the 228 participants who provided role information, 149 (65%) participated in the “metro” focus groups and 79 (35%) participated in one of the sessions held in “greater Minnesota.” Figure A2 shows the distribution of these participants by role and region. In the metro groups, “case manager” was the most common role, with the other participants divided fairly equally between “other county roles,” “provider or advocate” roles, and “family or self-advocate” roles. In the greater Minnesota groups, “case manager” was again the most common role, but relatively few other county staff members were represented (seven total).

**Figure A1 Assigned Roles**



**Survey Respondents by Role and Region**



**B. RESULTS**



Results at the September focus groups are reported according to the open-ended comments, survey responses, and group discussions.

**QUESTION 1: What Should Stay the Same About Case Management in Minnesota?**

Many of the participants came to the focus group meetings thinking that many good things were already being done in Minnesota’s case management system. As the first task at the focus groups, each participant was given the opportunity to write down their responses to this open-ended question.

Table A2 shows the things that participants thought Minnesota was doing well and should be retained during the case management reform process. Participants made 660 comments on this topic. Themes regarding what Minnesota does well that should stay the same focused on the following topics: keeping case management local, using independent case managers, using a consistent person as the case manager, providing county-based case management, maintaining strong case management practice standards regardless of who is the case manager, providing case management services based on people’s need regardless of their disability, maintaining high standards for case managers, providing flexible case management so that it meets individual needs, and continuing to have the county determine eligibility for services rather than another entity. There were many comments about specialization but not all agreed on whether case management specialization (for example by age, disability type, or waiver type) should be maintained or whether it was disruptive because consumers would be confused if they had more than one case manager assigned to them.

**Table A2: What do participant want to have stay the same in the new system?**

Local	Keep case management and services local, because local CMs and services can be responsive to the needs of the community, be knowledgeable about local resources and get to know clients and families well. There was strong support for the current county-based system.
Independent	Independent, impartial case management with no ties to providers and so there is no conflict of interest.
Consistent, person	Clients should have a single CM who is consistent over time so they can develop a relationship of trust. The CM helps guide the person/family through the complexities of the system. This is especially important for clients with no family or advocacy involvement. Clients/families should have the opportunity to change CMs or keep the same CM as they wish.
County based	Keep case management local, accountable and impartial with public (county) services. CM should not be financially dependent on billing clients. Counties have a stable workforce allowing continuity of CM services. Counties have expertise in working with difficult to serve groups. Counties retain responsibility for eligibility and oversight of expenditure of public funds.
CM Practice Standards	Qualified CMs who maintain professional standards of impartiality, regular personal (face-to-face) contact, have peer support, are knowledgeable and who receive ongoing education and training.
Needs based	People should get the services and supports they need, regardless of disability, where they live, insurance status or which waiver they use.
Safeguards	Ensuring health and safety, arranging background checks, eliminating conflict of interest, are all important client safeguards.
Specialization	Differing views on this issue. Some felt that specialization was important because it is impossible for the CM to know everything about every service and every disability. But others felt that it was disruptive and confusing for a client to have several CMs for different

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**Table A2: What do participant want to have stay the same in the new system?**

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	aspects of their life.
Flexibility	Meet individual needs by flexible use of services, providers and funding, and by supporting client/family choice.
Eligibility	Eligibility should continue to be determined locally by the county.

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## **QUESTION 2: How Should Minnesota’s Case Management System Be Improved?**

The second question for participants in the first round of focus groups was an open-ended opportunity to share ideas about how the Case Management System in Minnesota should be changed, reformed, or improved (see Table A3). Focus group participants offered 1,084 specific suggestions about how case management in Minnesota should be changed. From those comments, 14 themes emerged. The themes included improving access to services and clearer eligibility definitions, reducing case loads for case managers, increasing choice of case manager, providing improved training to case managers, increasing the consistency across counties and waivers in services, case management procedures and rules, simplifying and streamlining documentation requirements, increasing fairness and equity in funding and service provision, allowing more flexibility in case management practice, increasing secure long-term funding for needed services, improving current problems with host county case management, providing more needs-based services, increasing the focus on having one case manager for each person supported (as opposed to a case management team model), providing opportunities for families or parents to provide case management services, improving basic quality and service standards for case managers including response times to phone calls, improving the ease of use of data systems, and improving services for populations that are not currently well served.

These open-ended responses provided strong confirmation of the recommendations made in the interviews of representatives of 19 Minnesota counties.

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**Table A3: What changes did participants recommend for Minnesota's Case Management System?**

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Access and Eligibility	Access to all needed services and clearer definitions of eligibility.
Caseloads	Large caseloads don’t allow the CM to really get to know the person and their family and ensure person-centered quality services.
Choice of Case Manager	People should choose a CM who is compatible with them, knowledgeable, and from any provider (not just county).
CM training	CMs need training to be knowledgeable and to understand the system to help their clients.
Consistency	Consistency and compatibility in services, procedures and rules within and between counties, and across different waiver types.
Documentation	Paperwork, duplication –simplify, streamline, reduce to allow more client time.
Equity	Fairness in funding & service provision – across clients (with and without active family advocacy), counties and different waiver types.
Flexibility	Creative, person-centered and individualized options so that the person gets what he/she prefers and needs. Fewer rules to allow more creative responses to unique circumstances.
Funding	Increased, secure long-term funding for services. Less pressure on CMs to generate revenue. Simplify funding (e.g., single payer).

Multi-county issues	Less contact, poorer CM and inefficient for CM to remain with county of financial responsibility when the client receives services in another county. Host county should provide CM. Make client transfers from county to county easier.
Needs Based	Services should be needs based (regardless of diagnosis), not required to fit in to a prescribed slot or service. Promote independence and avoid over-servicing. Needs-based funding with client's choice of services. Develop a better tool to assess needs that is applicable to all groups (regardless of age or disability type).
One person	Have a single, consistent CM over time so they can develop a solid relationship with the client and get to really know that person's needs and preferences. "It's about the relationship - without a relationship between the client and the case manager, nothing else works, relationships take time".
Parents as CM	A good option for families who want this role. Gives greater family control of services and funding. Family control should be available regardless of which waiver is used.
QA and service standards	Need some basic quality and service standards for CMs, including response times for phone calls, letters etc.
Technology	Greater ease of use of data system(s) with databases that interface with one another easily.
Specific groups	Certain specific groups of consumers are relatively poorly served – people with MI, crisis services for children and adolescents, people with autism, people with MR and MI, people with mild/borderline ID who do not have an MR/RC slot, and people with severe disability who cannot express their needs or wants and have no family friends or advocates.

### **QUESTION 3: Survey Responses: 22 Recommendations for Improving Case Management Practices**

Interviews with county administrators, case managers, and public health nurses in 19 Minnesota counties yielded 22 recommendations for improving the case management system. These items were developed into the "county survey." (Appendix B) Focus group participants were asked to rate their agreement with each of the 22 items on a 5-point likert scale: 1. Strongly Disagree. 2. Disagree. 3. Neutral. 4. Agree. 5. Strongly Agree.

Figure A4 shows overall agreement with the 22 statements, with the statements that were most strongly supported listed at the top. Overall, participants agreed or leaned toward agreement with all 22 items. The most strongly supported recommendations were to:

- Improve information system process and comprehensiveness
- Provide more resources to counties for choices in housing and new service development
- Ensure that person-centered processes are used regardless of who provides case management
- Encourage creativity and more options for case management
- Improve data bases and the reports generated from them to assist counties to evaluate outcomes more effectively
- For managed care entities, increase the standardization of forms used, and reduce the bureaucracy of working with them
- Use more person-centered quality assurance processes
- Improve flexible case management options for counties and ensure that case managers are certified and trained adequately regardless of who they work for
- Improve the assessment used for persons receiving personal care attendant services

Analyses of variance (ANOVA) were used to determine whether focus group participants differed in their support for these recommendations depending on their region or respondent role (see Table A4, significant differences are highlighted in color). There were three items on which respondents in different regions responded differently. Specifically, participants in the metro region were more supportive of recommendations to improve databases and reports, and to improve information system processes and comprehensiveness, though both regional groups of “metro area” and “greater Minnesota” supported those ideas. On the other hand, participants in greater Minnesota were more supportive than metro area participants of the recommendation that DHS should provide more assistance to counties in rate setting and business practices.

There were differences by respondent role for five items. Specifically, providers and advocates were more supportive than county staff and case managers of the recommendation to provide on-line assessment processes consumers can complete themselves. Families and self-advocates were more supportive of this idea than were case managers.

While all groups were at least somewhat supportive of the idea of offering a common service menu across the various HCBS Waiver options, county administrators and planners were more supportive of this idea than were providers and advocates.

Again, while all groups generally supported the recommendation to use more person-centered monitoring processes (for quality assurance purposes), the groups “providers and advocates” and “families and consumers” were more supportive of this idea than the county and the case manager groups. Similarly, while all groups supported the use of person-centered case management processes, providers and advocates were the most supportive of this idea.

There were four items on which a complex interaction was noted between the groups and regions (see Figures A5 through A8). Specifically, there were no regional differences between case managers in their support of the recommendation to make databases more useful. Overall, respondents in the metro area were more supportive of this recommendation than respondents in greater Minnesota. However, amongst families and advocates, those in greater Minnesota were more supportive of this idea than those in the Metro, while amongst “providers and advocates” and “other county” respondents, those in the metro area were more supportive than those in greater Minnesota (Figure A5).

A similar pattern emerged regarding support for the recommendation to improve systems for nursing home diversions and movement from nursing homes. Overall, providers and advocates were more supportive than case managers of this recommendation. “Providers and advocates” and “other county” respondents in the Metro area were more supportive than their counterparts in greater Minnesota, while families and self-advocates in Greater Minnesota were more supportive of this recommendation than their counterparts in the Metro area (Figure A6).

The recommendation to improve information system process and comprehensiveness (make information flow better and more comprehensively) was supported by all respondents. But “other county” respondents from greater Minnesota were less supportive of this recommendation than the other groups (Figure A7).

Finally, the recommendation to reform how managed care entities were handling case management processes (standardizing forms and reducing bureaucracy) was supported more strongly by the “providers and advocates” and “other county” representatives in the metro region, and by the case managers and family members or self-advocates in greater Minnesota (Figure A8).

## **GROUP DISCUSSION**

After the survey was administered to each individual attending the focus groups, participants were asked to break into small groups and discuss which of the 9 areas of 22 recommendations were the most important and highest priority to address. The small groups rated these areas as the highest priority, in the following order:

1. Standardize, simplify, equalize processes (streamline processes).
2. Maximize individualization.
3. Encourage creativity and resource development.
4. Improve county capacity for quality assurance.
5. (tie) Standardize caseload size.
6. (tie) Concerns about private managed care.

**Figure A4: Recommendations for Improving Current Case Management Practices**

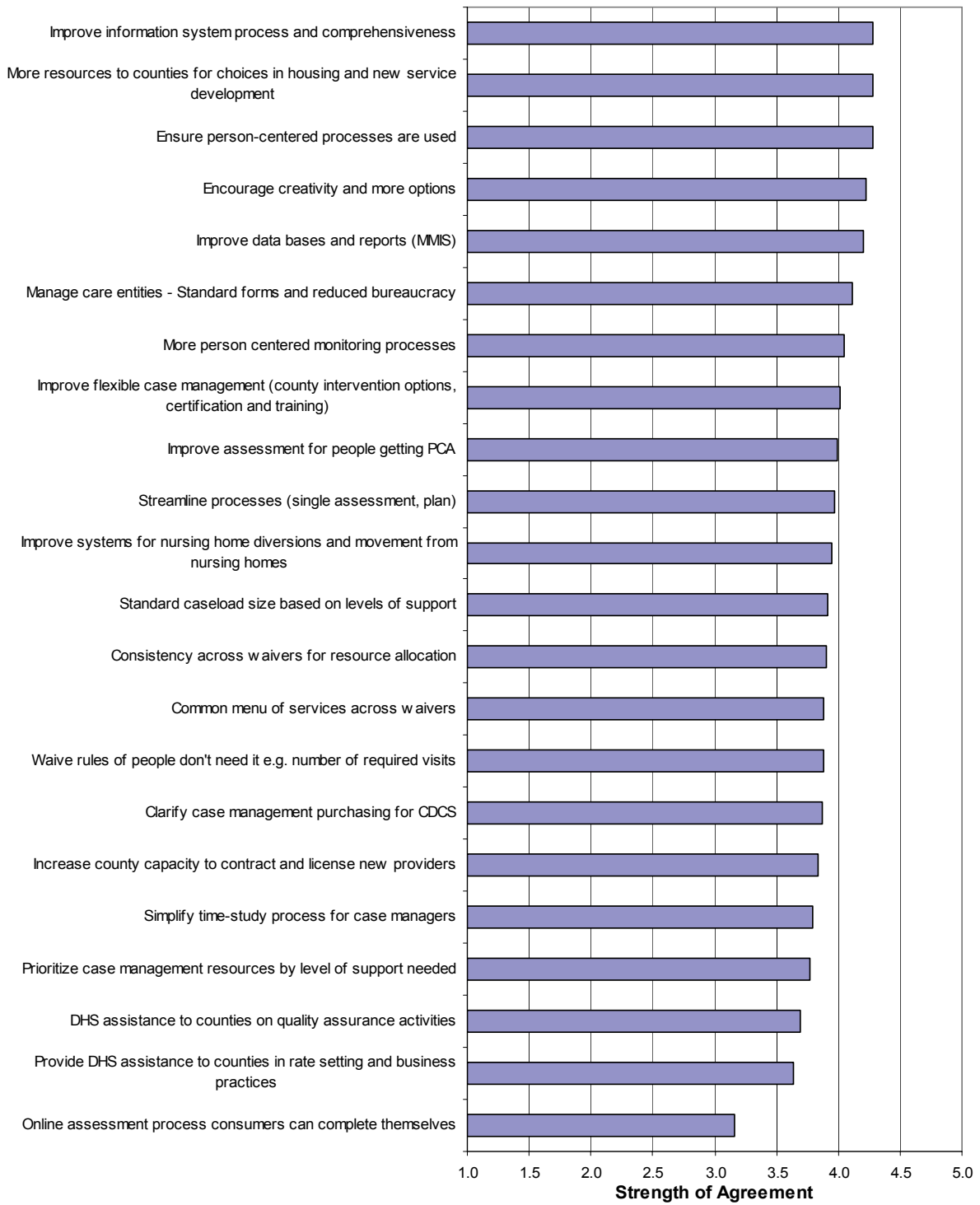


Table A4 Agreement of focus group members with specific case management structure changes for Minnesota: Differences by Region and Role													
Recommended Change	Overall Mean	Region		Respondent Role			Test of Differences			Region x Group	Overall		
		Greater MN	Metro	1 Other/ Provider	2 County Not CM	3 Case Manager	4 Family/ Consumer	Region	Diff			Group	Diff
Online assessment process consumers can complete themselves	3.16	3.15	3.16	3.96	3.11	2.59	3.59	0.21		14.33***	3 < 4,1; 2 < 1	0.97	7.87***
Provide DHS assistance to counties in rate setting and business practices	3.64	4.00	3.45	3.72	3.75	3.48	3.82	15.70**	M < G	2.87*		1.87	4.06***
DHS assistance to counties on quality assurance activities	3.69	3.77	3.65	3.88	3.74	3.60	3.78	0.42		0.39		1.79	1.41
Prioritize case management resources by level of support needed	3.77	3.72	3.80	4.00	3.72	3.65	3.78	1.34		1.67		1.45	1.10
Simplify time-study process for case managers	3.79	3.71	3.84	3.80	3.97	3.76	3.70	0.01		0.36		3.20*	1.70
Increase county capacity to contract and license new providers	3.84	3.86	3.83	3.83	3.82	3.80	4.11	0.19		1.11		0.40	0.61
Clarify case management purchases for CDCS	3.87	3.89	3.86	4.15	3.62	3.80	4.03	0.08		2.58		1.94	2.20*
Waive rules of people don't need it e.g. number of required visits	3.88	3.69	3.99	4.28	3.86	3.71	3.87	0.75		2.91*		1.42	2.19*
Common menu of services across waivers	3.88	4.07	3.78	3.73	4.35	3.84	3.84	3.42		2.03	1 < 2	0.30	2.08*
Consistency across waivers for resource allocation	3.91	4.05	3.83	3.96	4.18	3.82	4.05	2.63		1.19		0.76	1.34
Standard caseload size based on levels of support	3.91	4.13	3.80	3.84	3.74	3.97	4.29	1.91		1.10		0.16	1.30
Improve systems for nursing home diversions and movement from nursing homes	3.94	3.79	4.02	4.40	3.97	3.72	4.00	1.52		4.68**	3 < 1	2.79*	4.12***
Streamline processes (single assessment, plan)	3.97	4.04	3.99	4.09	4.18	3.85	4.16	0.30		4.80**		0.53	2.92**
Improve PCA assessment	4.00	4.00	3.99	3.87	4.28	3.95	4.00	0.04		1.94		2.23	1.85
Improve flexible case management (county intervention options, certification and training)	4.01	3.91	4.06	3.98	4.21	3.93	4.11	1.01		0.53		0.08	0.69
More person centered monitoring processes	4.05	3.88	4.14	4.65	3.90	3.73	4.42	3.56		12.96***	3,2 < 4,1	0.39	7.69***
Manage care entities - Standard forms and reduced bureaucracy	4.11	4.08	4.13	4.35	4.36	3.94	4.13	0.52		1.08		6.74***	4.17***
Improve data bases and reports (MMIS)	4.20	4.01	4.30	4.20	4.43	4.16	4.21	6.03*	G < M	0.60		5.56**	3.36**
Encourage creativity and more options	4.23	4.15	4.27	4.40	4.33	4.11	4.43	0.52		2.89*		2.23	2.07*
Ensure person-centered processes are used	4.28	4.17	4.33	4.74	4.21	4.06	4.48	1.12		7.63***	3,2 < 1	2.49	4.32***
More resources to counties for choices in housing and new service development	4.28	4.15	4.34	4.28	4.51	4.23	4.38	0.48		0.66		0.53	0.88
Improve information system process and comprehensiveness	4.29	4.12	4.37	4.38	4.28	4.27	4.34	7.63**	G < M	2.17		3.97**	2.26*

1 Strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, 5 strongly agree . G = Greater Minnesota, M = Metro, CM = Case Manager; Diff = Significantly different groups with the lower mean(s) listed first

Figure A5

Make data bases more useful: Differences by Region and Role

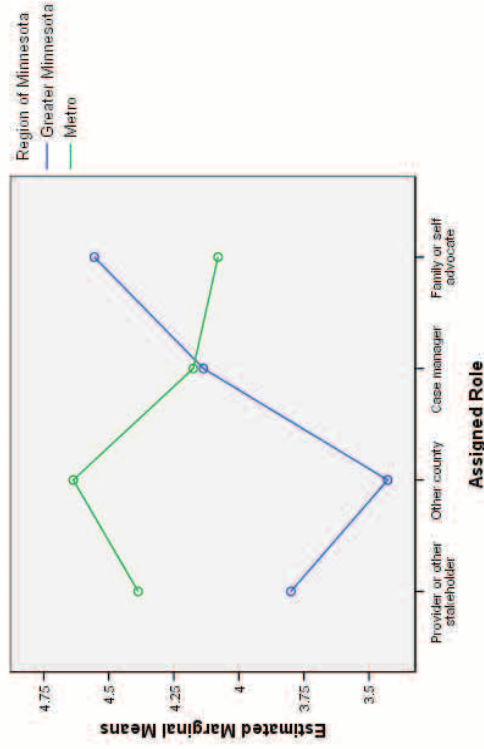


Figure A7

Make information flow better and more comprehensive by Role and Region

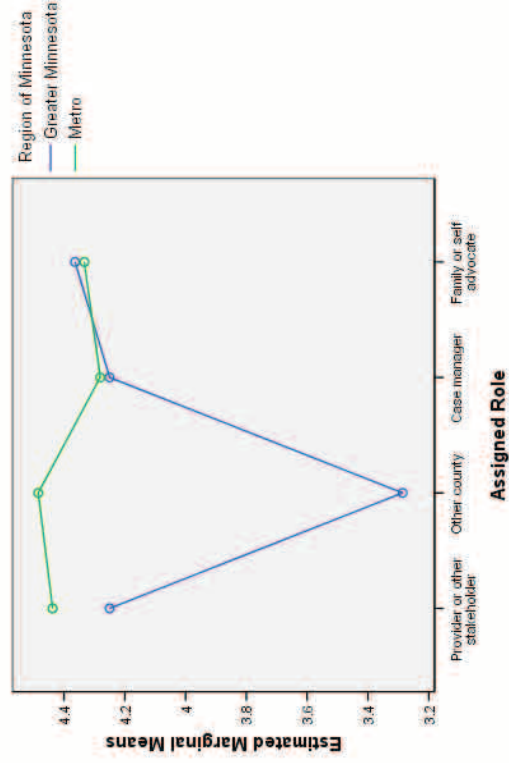


Figure A6

Improve systems for nursing home diversions and movement by Region and Role

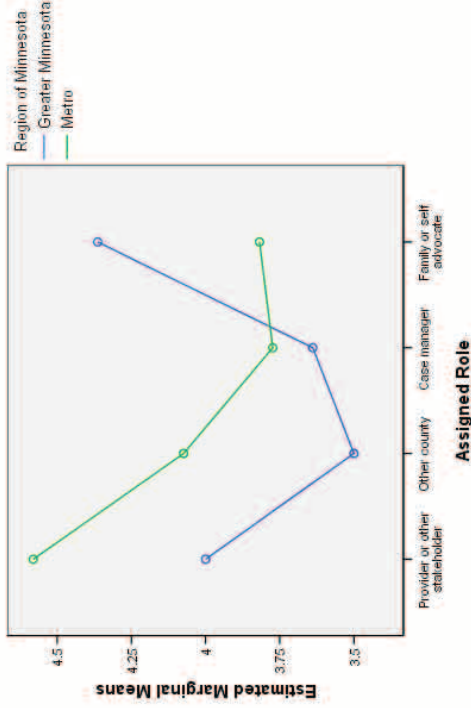
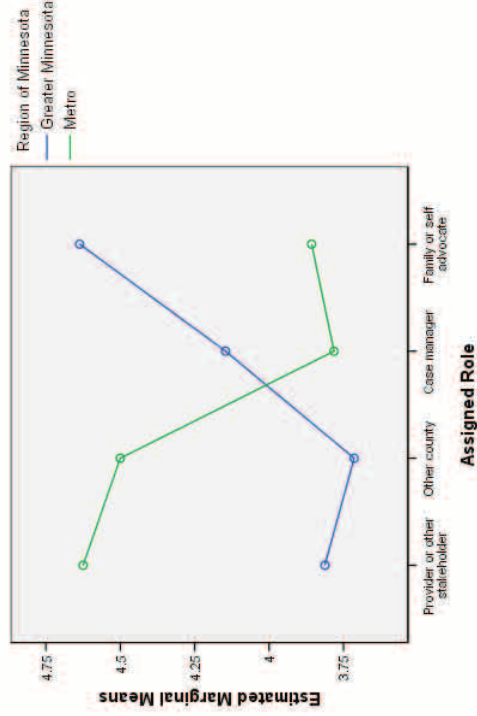


Figure A8

Reduce bureaucracy from different mgd care agencies and forms by Region and Role





#### **QUESTION 4: Survey Responses: Responses to Seven Other State Models**

Participants were provided with descriptions of seven types of reforms and innovative models that other states have implemented. Summary information about each reform model was also contained in the focus group handouts. As each reform was presented, participants had an opportunity to ask questions. A survey was distributed with these seven reforms and participants were asked to rate each of the reforms as to whether they thought Minnesota should pursue the reform. A five point likert scale was used to record their responses: 1. Strongly Disagree. 2. Disagree. 3. Neutral. 4. Agree. 5. Strongly Agree.

Table A5 shows the average agreement with the suggestion that Minnesota should pursue each reform. Overall the strongest agreement was with developing a resource allocation process based on assessment of need and current supports (3.83) and improving system coordination across stakeholder groups (3.76). The groups disliked the ideas of using privately administered managed care (1.92), and increasing the use of private case managers (2.76). (Since the largest majority of the focus group participants were county case management staff, this is not an unexpected result.)

Analysis of variance was used to test whether there were statistically significant differences between respondent groups regarding which recommendations they supported. There were many differences between regions and respondent groups. In each of the test of differences columns the ANOVA statistic F is listed. Asterisks are used to denote significant differences. Next to the region column, the column labeled “diff” shows which groups rated the item differently. For example, respondents in greater Minnesota (G) were much more supportive of the idea of using tiered levels of case management (allocating case management resources based on the needs of the person), and increasing the use of private case management, than were metro (M) respondents.

There were also significant differences between respondent groups on all but one of the recommendations (see the asterisks in the “group” column). The “difference” column next to “group” identifies the group numbers that were different from one another. For example, for recommendation 1 (Improved system coordination across groups), group 3 (case managers) were significantly less supportive of the change than groups 1 (providers and advocates) and 2 (other county staff). For recommendation 2 (changing the resource allocation process to be based on assessment of needs and current supports), case managers (3) were significantly less supportive than families or consumers (4), and providers or advocates (1).

On Item 3 (changing the structure of consumer directed community support services), a more complex pattern emerged (See Figure A9). Case managers in both the metro and greater Minnesota groups were opposed to this idea. Families or self-advocates in greater Minnesota were most supportive, along with metro area providers and advocates and metro area “other county staff.” Families in the metro area and “other county staff” in greater Minnesota were less enthusiastic about the proposal. Overall, providers were the most supportive of this recommendation, and case managers were least supportive of this recommendation.

The recommendation to increase the use of private case managers was supported most strongly by providers and advocates. Families and consumers were also supportive of the recommendation, but less so than providers. County case managers and other county staff opposed this recommendation.

“Other county staff” (planners and administrators) were supportive of the recommendation to use county-administered managed care which the other three groups were either mildly supportive or neutral on this question.

The recommendation to use privately administered managed care was opposed by all groups, with stronger opposition noted by county case managers and other county staff.

For all of the suggestions where differences between groups of respondents were noted, case managers were the least or next to the least supportive of change. Providers and advocates, on the other hand, were among the most supportive for all of the recommendations except using county administered managed care.

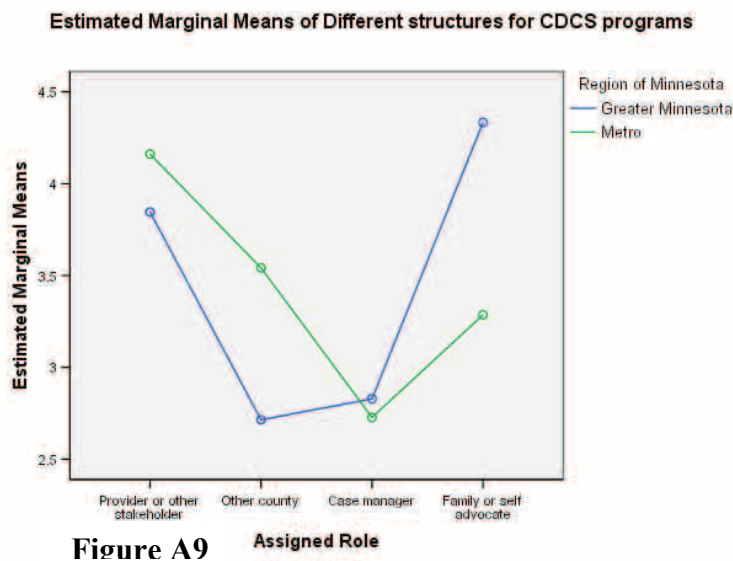


Table A5: Recommended Changes in Case Management Structure: Agreement by Region, Respondent Group, and for the Interaction between Region and Respondent group														
Recommended Change	Region		Respondent Group					Overall Mean	Test of Differences					
	Greater MN	Metro	1 Provider/Other	2 Other County	3 Case Manager	4 Family/Consumer	Region		Diff	Group	Diff	Region x Group	Diff	Overall
1. Improved system coordination across all groups	3.91	3.81	4.23	4.00	3.39	3.76	3.76	0.30		4.80**	3 < 1,2	0.53		2.92**
2. Allocation process based on assessment of need and current supports	3.79	3.95	4.11	3.64	3.56	4.15	3.83	0.98		3.96**	3 < 1,4	1.34		2.46*
3. Different structures for CDCS programs	3.43	3.43	4.00	3.13	2.78	3.81	3.32	0.00		13.8***	3 < 2,4 < 1	3.48*		7.96***
4. Tiered levels of case management support (like NJ model)	3.80	2.86	2.93	3.06	3.28	3.38	3.11	19.9***		2.01	M < G	0.17		4.60***
5. Increase use of private case managers	3.22	2.74	4.06	2.18	2.03	3.65	2.76	5.93*		33.53***	3,2 < 4 < 1	1.75		16.53** *
6. Use county administered managed care	3.21	3.44	2.93	4.11	3.06	3.20	3.30	1.32		7.98**	3,1,4 < 2	2.48		3.35**
7. Use privately administered managed care	1.89	2.04	2.31	1.62	1.59	2.32	1.92	0.59		5.38**	3,2 < 4,1	1.66		4.34***

ns = not significant \* p < .05, \*\* p < .01, \*\*\* p < .001

## **GROUP DISCUSSION**

After each participant responded to the survey, participants were asked to discuss in small groups which of these options from other states were the highest priority and most important to pursue in Minnesota. The groups rated the following items as highest priority, in the following order:

1. Resource allocation – planning creative options requires increased assistance to counties.
2. Increase privatization/provide choice of Case Manager (rated most highly by providers and family members).
3. Systems coordination across all disability groups.
4. Tiered levels of support (rated most highly in greater Minnesota).

## **APPENDIX F**

### **COMPARISON OF PERFORMANCE STANDARDS AND FUNDING STREAMS**

Table 1 – Minnesota Standards of Practice across Funding Streams

Table 2 – Minnesota Comparison: Case Management and Reimbursement of Travel Time  
Across Funding Streams

Table 3 - Standards of Practice in Other States across Funding Streams

<b>Table 1: Minnesota Standards of Practice Across Funding Streams</b>				
	<b>Face-to-face visits per year</b>	<b>Phone or written contact</b>	<b>Reassessment</b>	<b>Review of plan</b>
<b>MR/RC</b>	Semi-annual	Quarterly written reports	Annual	Annual
<b>CADI</b>	Two a year	Varies, no requirement	Annual	Annual
<b>CAC</b>	Two a year	Varies, no requirement	Annual	Annual
<b>TBI</b>	Two a year	Varies, no requirement	Annual	Annual
<b>EW</b>	Semi-annual	Varies, no requirement	Annual	Annual
<b>PCA</b>	None required (case management is not required)	Varies, no requirement	Annual face-to-face for PCPO)	Annual
<b>Home care</b>	None required (case management is not required)	Varies, no requirement	Varies based on services	Annual

**Table 2: Minnesota Comparison: Case Management and Reimbursement of Travel Time Across Funding Streams**

<b>Can Case Management Providers Bill Travel Time In Addition To Direct Contact Time?</b>	<b>YES</b>	<b>NO</b>
AC Program Case Management		<b>X</b>
Relocation Service Coordination	<b>X</b>	
<b>Screening</b>		
DD Screening	<b>X</b>	
LTCC Screening (Under 65)	<b>X</b>	
<b>Targeted Case Management</b>		
CW-TCM		<b>X<sup>2</sup></b>
Home Care TCM	<b>X<sup>1</sup></b>	
MH-TCM		<b>X<sup>2</sup></b>
VA/DD-TCM		<b>X<sup>2</sup></b>
<b>Waiver Case Management</b>		
CAC Waiver CM		<b>X</b>
CADI Waiver CM		<b>X</b>
EW Waiver CM		<b>X</b>
MR/RC Waiver CM	<b>X</b>	
TBI Waiver CM	<b>X</b>	

<sup>1</sup> To be implemented on 7/1/05

<sup>2</sup> Uses a monthly, cost-based rate that includes indirect costs such as travel time.

<b>Table 3: Standards of Practice in Other States Across Funding Streams</b>					
<b>State</b>	<b>Face-to-face visits required</b>	<b>Other contact required</b>	<b>Reassessment</b>	<b>Review of plan</b>	<b>Other</b>
<b>Kansas</b> <i>MR/DD</i>	Annual	None	Annual	Annual	
<b>Pennsylvania</b> <i>MR Waiver, Consolidated</i>	Monthly (3 times per quarter)	None	Annual	Annual	Families can put in writing request to waive visits
<b>Pennsylvania</b> <i>ICF-MR</i>	Every 90 days	None	Annual	Annual	Families can put in writing request to waive visits
<b>Pennsylvania</b> <i>School age and other services</i>	Annual	None	Annual	Annual	Families can put in writing request to waive visits
<b>Pennsylvania</b> <i>Person/Family Directed Support Waiver</i>	2 per 6 month interval	None	Annual	Annual	Families can put in writing request to waive visits
<b>New Jersey</b> <i>Self-Directed</i>	No standard, set at person's discretion	None	Annual	At persons request, up to 10x per year	
<b>Wyoming</b> <i>DD and ABI (acquired brain injury) waivers</i>	Monthly	60 minutes face to face OR phone contact per month	5 years for adults; 3 years for children	Annually	
<b>South Dakota</b> <i>DD</i>	Monthly	Varies by level of service funded	Annual	Annual	Monthly monitoring of objectives and quarterly observations required by service coordinator is required.
<b>Utah</b> <i>DD and ABI (acquired brain injury) waivers: day/residential services</i>	Monthly	None	Annual	Annual	Interdisciplinary teams required for ABI as well as DD



<b>Table 3: Standards of Practice in Other States Across Funding Streams</b>					
<b>State</b>	<b>Face-to-face visits required</b>	<b>Other contact required</b>	<b>Reassessment</b>	<b>Review of plan</b>	<b>Other</b>
<b>Utah</b>	Once every 3 months	Monthly contact	Annual	Annual	Interdisciplinary teams required for ABI as well as DD
<i>DD and ABI (acquired brain injury) waivers: in-home or self-administered program</i>					
<b>Utah</b>	Annual	Monthly	Annual	Annual	If high risk CIL contracted for additional visits
<i>PD</i>					
<b>Arizona</b>	Annual	Annual	Annual	Annual	
<i>State services (non-waiver)</i>					
<b>Arizona</b>	Every 90 or 180 days, depending on residential setting, age, and services	None	Annual	Same as visits	
<i>Medicaid (nursing facility level of care, waivers)</i>					
<b>Arizona</b>	Annually	Annual contact can be face-to-face or by phone	Annual	Annual	
<i>Targeted (non-Medicaid, non-waiver services)</i>					
<b>Arizona</b>	Every 180 days team meeting required	None	Annual	Every 6 months	
<i>Early Intervention</i>					
<b>Maryland</b>	Quarterly	None	Annual	At least annually	Plan is monitored during quarterly visits/documented
<i>TBI</i>					
<b>Maryland</b>	Semiannual	Bi-monthly	Annual	Every 6 months, or more if team determines	Most often CM report more frequent visits; plan reviews quarterly
<i>DD</i>					
<b>Florida</b>			Annual	Annual	

<b>Table 3: Standards of Practice in Other States Across Funding Streams</b>					
<b>State</b>	<b>Face-to-face visits required</b>	<b>Other contact required</b>	<b>Reassessment</b>	<b>Review of plan</b>	<b>Other</b>
<i>DD Waiver</i>	Monthly if licensed residential; Quarterly if living in own or family home	Bi-monthly contact			Two of those contacts per year must be at the residence, at six month intervals