MINNESOTA DEPARTMENT OF HUMAN SERVICES

DISABILITY SERVICES DIVISION

Creating Service Options and Choice In Homes and Communities

Case Management for Persons with Disabilities in Minnesota

A Status Update on Reform Efforts and Preliminary Findings to the Legislature

April 2005

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Legislation

The 2003 Minnesota Legislature required the Department of Human Services to report to the legislature on the redesign of case management services. The authorizing legislative provision reads as follows:

> The commissioner shall report to the legislature on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties and service providers. The report shall include draft legislation for case management changes that will:
>
> (1) streamline administration,
> (2) improve consumer access to case management services,
> (3) address the use of a comprehensive universal assessment protocol for persons seeking community supports,
> (4) establish case management performance measures,
> (5) provide for consumer choice of the case management service vendor, and
> (6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

The proposed legislation shall be provided to the legislative committees with jurisdiction over health and human services issues by January 15, 2005.

Background and Introduction

Disability services in Minnesota are primarily community based. Institutional services are used by less than six percent of people with disabilities who are under the age of 65 years and are enrolled in services through the human services system.[1] Minnesota serves more than 91,000 people with disabilities in its Medical Assistance Program. In addition, other people with disabilities are served by a variety of non-Medical Assistance health and social service programs.

Many individuals with disabilities access and manage the community-based services and supports they need on their own, while others rely upon the help of a case manager. When seeking help, people want to know:

- What services and supports they are entitled to receive.
- What services and supports are available in their location.
- How fast these services and supports can be made available to meet their needs.

Under Minnesota's Medical Assistance program, also referred to as Medicaid or MA, basic health services (such as physician, lab and hospital), institutional services (long-term hospital, nursing home and intermediate care facility placement) and home care services (skilled nursing, home health aide and personal care assistance) are **entitlements** for people with disabilities who demonstrate a need for this level of care. Under the entitlement provisions of the Medicaid program, people are legally guaranteed access to services and benefits for which they qualify, generally within 90 days.

There are other Medicaid services used by people with the same level of needs that are **not** classified as entitlement programs/services. Such are the Medicaid home and community-based waiver programs. These "waivers" to Medicaid regulations are alternatives that Minnesota has opted to offer in lieu of institutional placement. Minnesota is required under federal regulations to demonstrate that services provided under the waiver programs cost no more on an average basis than the comparable

[1] For the purposes of this report, the term "disabilities" refers to people under the age of 65 years who meet the Social Security Administration's definition of disability or have been determined to have a disability through other state-authorized processes.

institutional services. Minnesota is also required to seek federal permission for the number of people to be served by these programs, assuring the federal government that the programs are only serving people who would otherwise be using institutions for long-term care services. Thus, the waiver programs have caseload and funding limits unique to each program. As people are neither entitled to these waiver programs nor guaranteed access to these services within any timeframe, it is typical to see waiting lists.

For a number of years, public policy in Minnesota has been to encourage people to use community services through the waiver or home care programs instead of institutional services. Home and community-based waiver program caseloads have been growing since the early 1980's, while institutional bed capacity and demand for institutional services have decreased. Minnesota has elected to offer these waiver program alternatives and to retain only enough institutional capacity to assure that people who choose an institutional placement can access it. This balance of entitlement and non-entitlement offerings has been a challenge to maintain in correct proportions. Case managers are increasingly identifying people who want services through the waiver programs but may have to enter an institutional placement until the waiver program funding becomes available.

Minnesota is somewhat unique with respect to its success in converting institutional capacity and funding to these home and community-based waiver and home care programs. Most other states are clearly heading in the same direction but have not been as successful in implementing this as a broad public policy. Thus Minnesota's progress in this respect means that the accompanying challenges are ones for which there may be limited experiences elsewhere to turn to when seeking answers.

How Minnesota Currently Provides Case Management to Persons with Disabilities

In Minnesota, people with disabilities typically obtain case management assistance from county agencies when they need some combination of health, continuing care or social service. Minnesota's statutes have established a state-supervised county-administered structure that designates a county (and in some cases, a tribal entity or health plan representative) as the central agency within which public, social and health care services are organized at a local level. Counties share a financial responsibility with the state and federal government for the services provided to people with disabilities. For instance, counties pay for approximately one third of the cost for case management services. In 2002, the Department of Human Services (DHS) completed a report to the

legislature that indicated the total spending for case management services for people with disabilities enrolled in human services exceeded 200 million dollars annually.

Two major types of functions are performed by the counties in fulfillment of their responsibilities to provide case management services to persons with disabilities. The first function is an administrative **gate keeping** function, which involves assessment, eligibility determination and authorization of funding for services. The second function is **service coordination**, which involves assistance to individuals in finding ways to meet needs. Service coordination may include accessing formal services or informal community resources, coordinating the provision of services across health and continuing care service, advocating for resources needed by an individual, evaluating service effectiveness, assuring health and safety and assisting the individual when needs change.

A summary overview of the major case management activities may be helpful. The activities in which case managers are routinely engaged include the following:

- Assessing needs and circumstances of individuals seeking assistance.
- Determining eligibility for various programs and services.
- Assisting individuals with developing and designing plans for service that are coordinated and comprehensive.
- Assisting individuals with finding providers.
- Obtaining authorization for funding of services.
- Monitoring service quality and outcomes.
- Routinely reviewing situations for needed modifications to services.
- Assuring health and safety.

The Disability Case Management System that has Evolved in Minnesota Has A Complex Structure

Within each of the previously identified case management activities, a number of actions are necessary to occur. The specifics of the actions vary depending upon the eligibility of the person, the programs selected by the person and the personal circumstances of the individual and his/her family.

The complexity of the case management system is evidenced by a number of characteristics of the disability services system including:

- Combination of gatekeeper and service coordinator functions, sometimes by the same person or work unit within the county agency.
- Varying program requirements across program areas and sub-population groups.
- Differences in standards for who can provide case management services across various programs and sub population groups.
- Challenges of integrating data and information for service recipients who may receive more than one type of service.

In addition to multiple state regulatory differences, financial incentives exist for the duplication of efforts and overlapping of case management responsibilities. This is because, frequently, the standards and requirements that do exist are linked to receiving reimbursement from the federal government by the incorporation of these standards/requirements into the state Medicaid plan (targeted case management services) and 1915c waiver service agreements with the federal government. An example of how this plays out is as follows:

> *Adults with serious and persistent mental illness who are MA eligible, qualify for Mental Health Targeted Case Management as a regular MA benefit. Counties pay the non-federal share of the cost and recoup the federal revenues for half of the cost of the service. Many of these same adults are also receiving services through an MA waiver program, such as Community Alternatives for Disabled Individuals (CADI), if they are eligible for nursing home level of care. Case management is a service that must be provided for any CADI recipient, with the State paying the non-federal share and the county collecting the combined state and federal payment of the claim.*
>
> *A number of counties have assigned TWO case managers to these recipients, and collect revenue for legitimate work done by both on behalf of the one recipient. There is nothing in Minnesota law or rule that requires this to happen. More frequently, this occurs because of the way in which the county chooses to manage, in that, the Mental Health division of the county is separate from the division managing waiver programs and the activities of each area may vary somewhat. In actuality, the same case manager can serve both functions. How that would impact revenues to the county depends upon how the county chooses to bill and manage. But, needless to say, the confusion for consumers, created by assigning multiple case managers, is one of the most frequent complaints expressed to DHS. Consumers do not necessarily feel that two is better than one.*

Having said this, to a large extent, the complexities of Minnesota's case management system are simply a reflection of the broader complexity of the various programs and services available to people with disabilities. In reviewing material for this report, DHS found that substantive reform to case management would be difficult outside of the larger context of how the State has chosen to administer its various disability services.

At the current time, investments for the disability system are approaching 1.5 billion dollars per year. Given the public policies and large investments in a range of community services, the overlap in service programs and the use of programs by people with a broad range of disabilities, Minnesota may be reaching a juncture at which a review of structure and a redefinition of what people can expect to receive is needed.

Case managers are already at the forefront of dealing with these issues. Case managers must know about and deal with the overlapping eligibility for programs, increased choices for consumers, tensions created by limits on non-entitlement services and the variation of rules, standards and reimbursement from program-to-program. Some of these issues are highlighted in this report and are ripe for further discussion as Minnesota continues to expand community service options.

Key Ideas Resulting from Initial Discussions

Following the 2003 Legislative Session, the Department of Human Services (DHS) began a series of conversations with stakeholders regarding how to approach the expected case management reform proposal. Through conversations with counties, advocates, federal officials and other stakeholders, it became clear that a shared vision about the direction that reform should take does not exist at the current time. The parties were not able to agree to what extent case management needed to be reformed. Most of the changes that were desired, spilled over to broader system issues. Budget pressures in all parts of the system also appeared to make it less likely that the parties would agree upon a specific course of action. It became quite clear that the reform of case management services is intrinsically linked to the overall structure of disability services, and that extracting case management **alone** for reform purposes did not appear to meet the desire for change.

Nonetheless, from these stakeholder conversations, a couple of key ideas did emerge as important backdrops to a case management reform effort.

A Broad Approach To Case Management Reform is Needed: People with disabilities access a broad range of health and continuing care services in a variety of ways. Even among people with similar diagnoses, there may be very different choices in the services selected and the mode of delivery. Increasingly there is crossover among disability subgroups within programs available in Minnesota, so that within any particular service or program, there is a broad representation of disabilities. This flexibility to tailor services to individual need and choice, combined with the ability to migrate across program and service types, indicated that recommendations would need to be broadly applicable across the many disability groups and should consider the need for coordination between basic health care and continuing care services.

Variations in Service Access and Program Funding Levels Are Faced by Case Managers Attempting to Assist Individuals and Should Be Addressed: Program/service histories and the level of access to services vary widely based on the program and population group. The ease and level of access to funding for individuals are heavily dependent upon historical costs for people with particular categories of need or diagnosis. Stakeholders do agree that it is in the best interest of consumers to have home and community-based services work equally well for all. Thus, it is essential to understand what case managers face in

terms of the variances in access to these service and the funding levels among the subgroups within the disability population.

Similarly, the evolution of disability services and the history of events have differentially affected county agencies charged with the responsibility to locally administer services. The challenges faced by individual counties may vary depending upon size, location and general economic conditions of the county. County boards, too, have differing opinions about the level of financial and legal risk they are willing to accept on behalf of the county. Consumers express that these local differences have resulted in unevenness and inequities in accessing services.

Stakeholder Discussion Causes DHS to Rethink Its Approach

Because the stakeholder conversations left more questions than answers about potential recommendations in changing the way in which case management services are offered, DHS decided to rethink its approach. Actually, the discussions begged the question of where even to begin, since much of the discussion overlapped with broader system issues.

As a way to focus effort, DHS reflected back on the resources, discussions and events leading up to the mandate for a report. This included reviewing the events in the 2003 Legislative Session, previous reports about case management and discussions that occurred with members of the legislature. Two pathways to developing initial recommendations emerged as the result of this "regrouping" effort.

The first pathway that will be discussed focuses on issues that contributed to most of the concerns raised in the 2003 session. The second pathway to developing recommendations focuses on the need to have future approaches to case management fit within a home and community-based services system. Some important and challenging implications of each are discussed in the following sections of the report.

Pathways to Initial Reform Findings/Recommendations

Pathway indicated by legislative discussions: Much of the discussion that occurred in the 2003 Legislative Session centered on two areas of practice:

1. Consistency and fairness in assessing and identifying needs (service coordination functions) and
2. Equity and fairness in allocating resources so that needs are met no matter in what community a person may reside (gate-keeping functions).

Concerns were expressed that multiple assessment processes exist and that Minnesota's system was not standardized enough to assure equity and fairness. Concerns also were expressed about the variation from county-to-county and case manager-to-case manager in how services were planned and authorized. While case manager expertise may vary, the underlying challenge that people seemed to want addressed is the process for assessing, identifying needs and allocating resources. This sort of change in the processes was identified as needed, no matter who was providing the case management services.

Pathway indicated by other developing issues: Concurrent to the public discussion described as part of the 2003 session, Minnesota's services for people with disabilities have continued to move along the path of being community-based, consumer-driven and flexibly able to meet individual circumstances. This dispersed and highly individualized model of service places new demands upon case managers and upon those responsible to administer services. This report is going to touch upon two specific areas of interest:

1. Infrastructure for performing the required functions and
2. Evolving questions around public policy development.

During the past year, the Department of Human Services (DHS) worked with independent contractors and collected information from counties and other stakeholders regarding a number of issues relating to disability services. One of the areas in question dealt with the adequacy of the infrastructure to provide case management and to administer services at the county level.

The survey results suggest that the investments needed to operate and maintain operations at a desirable level of performance have not kept pace either with the

expansion of community services or with the changes in state regulation and statute. The following are some of the problems cited:

- Case loads for case managers average about 1:60 on a statewide basis. A caseload ratio of 1:30 is generally the desired level.
- Case managers lack tools that will help their efficiency and effectiveness. Examples include: *Lack of access to needed information about consumers and service providers/networks, lack of standardization across programs, and duplicative requirements in administrative functions.*
- Case management supervisors have few tools to identify problematic situations. Examples include: *Lack of consistency in the content and comprehensiveness of service planning across disability subgroups and programs, lack of technology supports to track completion of required functions and time reporting.*
- Information systems at the state and local level fail to provide a means to integrate data and information across systems. This results in an inability to look at the data or service outcomes across a population group.
- Information systems are typically geared toward time tracking and claim information. This results in management reports that are inadequate, providing an incomplete picture for the states and counties to manage the operation of a multi-million dollar system of services.
- There have been limited investments in the skill development required for case managers and administrators who must manage the operational aspects of services, maintain budget integrity, assure individual rights and monitor the quality of a dispersed community-based service continuum.

The other area highlighted by the surveys and DHS conversations with stakeholders pertains to the question of what people with disabilities can expect to access when they enter statewide programs such as Medical Assistance (MA). At one time, the entitlement was the institution. However, that entitlement has been replaced by a variety of alternative programs which meet needs in ways not formerly available to people. While the legal responsibilities of the state limit people's access to non-institutional services, the public policy that has been adopted encourages the use of these alternatives. And the expectations of stakeholders have forever been changed as a result of the last twenty years of this public policy.

These issues raise questions for which there are not generally easy answers; but how Minnesota responds will have significant impact on the consumer and the case management system best able to assist that consumer.

The following section of the report attempts to identify several of the key policy questions related to this report and recommendations for reform. As the reader will see, these are challenging questions without ready answers. And although each is outside the scope of the original mandate for case management reform, these questions are examples of what is at the heart of case management reform issues.

Overview of a Few Key Policy Questions Raised in Preparing This Report

Should Minnesota establish an entitlement for community-based services that incorporates services currently available only under waiver programs?

This report has already established for the reader that Minnesota's public policy is heavily geared to offering people alternatives to institutional placement through entitlements to home health care, personal care assistance, targeted case management for discreet populations, and through non-entitlement waiver services. It has been well established that in the aggregate, community services have saved the State millions of dollars by avoiding the need to build additional institutional beds, and by offering people a package of services tailored to their specific level of need. This public policy has also allowed thousands of people to continue their participation and inclusion in community and family.

Minnesota is currently at a place where its legal obligation for entitlement services is technically the institutional choices in the MA program, BUT Minnesota's public policy has established a consumer desire and expectation for non-institutional alternatives. Concurrently, federal waivers require states to demonstrate that the cost of waiver services is on average no more than the comparable institutional services. Given that Minnesota has almost eliminated reliance on institutions for the disability population, we have reducing validity in our comparisons between the entitlement and non-entitlement services. Within the next five years, it is likely that Minnesota will need to undertake a serious effort to redefine entitlement services if the current public policy continues.

As a part of this report on case management, the legislature has actually asked the Department to look at some of the issues, which lend themselves to the broader discussion of entitlements. For example, *the legislature identified that there needed to be a better way to define the level of resource and service that individuals have a right to expect.* This is a critical question if and when Minnesota desires to redefine entitlements to include some of the non-institutional alternatives that are now only provided under the waiver programs.

How does case management relate to this?

Two steps in the case management process seem to be most closely aligned to the question of fair/equitable resource allocation and the individual's right to service:

1. Assessment of needs and personal circumstances and
2. Service planning.

These two steps heavily impact the resource amounts needed to pay for services. And the process ultimately chosen needs to attain both a reasonable level of standardization so that people are treated equitably AND a reasonable level of flexibility so that people with exceptional circumstances can get adequate levels of service.

While the question remains open concerning any decision to define entitlement differently, it is imperative that we address issues that can help inform any discussion at a future date.

As services become more individualized, how do we define the outcomes we want for the service system and for the individual?

The public policy discussions related to outcomes are important, in that, these public policy decisions will impact the decision about entitlements (rights to services) and the quality of life of individuals. The defined outcomes for the service system have a direct correlation to resource allocation at an individual level and the appropriation of funding at the statewide level. It has been difficult to find a way to talk about these goals. One possible way to think about the goals for services might be to look at the following three strata of outcomes:

- Goals related to meeting the basic health and safety needs of individuals being served.
- Goals relating to ongoing wellness, training and skill enhancement that increase independence and inclusion in community, and to reducing reliance on services.
- Goals relating to maintaining a standard of living and quality of life that extends beyond health, safety and increased independence, and is defined by individuals based upon their culture, age, experiences and personal choices.

To provide the reader with one example, let us address the question of goals related to **safety**:

As services have become more individually tailored, it has become more challenging to consistently define even the basic measures the State might choose for safety. Safety as defined in the federal regulations speaks primarily to the state's Medicaid program insuring that providers of service meet standards established by the state. Safety is not defined by state statute or rule for the purposes of disability services, but instead, relies upon the service planning process to define the personal safety needs of an individual. Thus, the State relies upon the professional judgment of licensors, social workers, case managers and the outcomes of individual legal cases to determine whether the system is meeting safety goals for each individual.

At an individual level, the concepts of safety may vary depending upon the experiences and circumstances of the person. And frequently people disagree about the level of risk that is acceptable and necessary when supporting a person to grow and learn new skills.

The advantage of this very individualized approach is the flexibility it gives to meet unique needs. The challenge of this is that case managers (and the legal system of dealing with consumer appeals) are routinely faced with "gray" areas, having little guidance to rely upon in helping to make decisions about the authorization of resources, funding and services.

Finally, as a "system" we have limited means to collect measures or data to evaluate how we are doing with respect to balancing the safety needs of individuals with the desire and cost of assisting individuals to increase independence and skill attainment.

Will the State guarantee a viable community option for each person with a disability?

Another public policy challenge will be in the decision about at what levels the State will guarantee entitlements to services across the various subgroups of people with disabilities. For instance:

- To what extent will natural supports, such as the availability of family and friends to provide care, be considered when allocating individual resources?
- To what extent will the State be flexible in allowing nontraditional services or modes of delivery to be used as part of an entitlement to service?

- To what extent will the State be willing to equalize access to services and resource amounts across the various disability groups?

Many questions will be raised as we continue to look at issues of resource allocation tied to assessment of individual needs and circumstances. Some of Minnesota's programs are already using the concepts of resource allocation tied to need assessment as a way to allocate funding into aggregate budgets. But the current use of "assessment-tied to resource allocation" is self-contained within specific programs and limited to historical use and cost of institutions.

For example, an individual entering a program, which uses nursing facilities as its comparable institutional cost, will have access to less overall resources than a program which uses Intermediate Care Facilities for Mental Retardation or Related Conditions (ICFs/MR) as its comparable institutional cost. The average cost of a nursing facility is $136.49 per day. The average cost of an ICF/MR is $223.02 per day. Thus, the aggregate budgets allocated to the counties to serve people who would otherwise be in a nursing facility are less than the aggregate budgets available to serve people who would otherwise be in an ICF/MR, even though the need for supervision, assistance and community integration may be the same.

Action Steps Taken in Addressing the Legislative Mandate

The Department of Human Services (DHS) finally decided to focus on **four** major areas of activity in moving forward with reform in the area of disability services and case management. DHS felt that some combination of continuing research, findings or recommendations to the legislature that provide incremental changes, and implementing quality improvement activities was a doable strategy. Limitations on Department administrative resources, the broad scope of this legislative charge and the challenges of initiating case management redesign outside of the multiple policy, program and financial areas that it exists within, has lead to this incremental approach to the changes.

A summary of the major strategies, activities to date and status of each follow:

One: Reviewing Previous CM Report Findings and Options

Over the past decade, DHS has several times provided the public and policy makers with information concerning case management. Earlier reports have provided information about the various funding sources for case management activities and made initial recommendations to move towards developing common performance standards.

The two most recent reports pertaining to case management were submitted in 2000 and in 2002. These reports identified issues and suggested options that the legislature might consider in its desire to make changes to case management. The following is a brief synopsis of a few of the key findings and options relating to reform interests.

Streamlining Case Management Administration

The earlier reports on case management attempted to provide information about the multiple ways in which case management is administered. As earlier noted, Minnesota offers case management as an entitlement service under the state's regular Medicaid plan for some populations (targeted case management). Others are paid through Medicaid waiver programs. Case management may also be offered as part of the child welfare system or through prepaid medical coverage. Finally, in other cases, county agencies provide case management as a general county service because of the person's vulnerability or diagnosis.

Generally, most stakeholders and policymakers agree that this hodgepodge approach invites duplication and causes confusion among consumers. As stated earlier, consumers report that multiple case managers have been assigned to assist them in some cases. This seems to be due to the organizational structure of Medicaid or other programs utilized by the consumer, the structure and the expertise of the county agency, or the incentives of financing and the generation of federal revenue to the state or the county agency.

To consolidate the administration of case management, one option suggested by stakeholders was to administer all service coordination activity as a "targeted case management" benefit under the Medical Assistance (MA) state plan. Practically speaking, this alternative would involve transferring the current costs and services from Medicaid waivers programs to the regular Medicaid plan and would open this service as an entitlement for people having a need. It would allow, however, for opportunities to equalize reimbursement, reduce duplication, expand provider systems and reduce inconsistencies in case management standards across population groups and programs.

The reader must remember, however, that related to this is the role that the gate-keeping functions of case management play in assessing and authorizing services for people that are on the waiver programs. These gate keeping functions **do not qualify for reimbursement** as a component of the "targeted case management services". Thus, a separate but related structure for gate keeping functions would be required. (Reminder: This gate keeping function is considered to be an administrative duty of the Medicaid program. Gate-keeping functions are generally done by agents of the state and qualify for federal financial participation when performed by the agent. It is not considered a service to the recipient and would not be eligible for reimbursement as a targeted case management service to the recipient.)

DHS expects that collapsing case management into the regular MA benefit as a "targeted case management service" would result in increased costs for several reasons. It is likely to increase case management costs per person and likely to result in overall cost increases to services resulting from better monitoring and advocacy by case managers. While these improvements to service are definitely a desired outcome, it must be decided within the budget context faced by the legislature.

Expanding Case Management Provider Options

Closely related to the previous proposal of consolidating case management under the umbrella of a "targeted case management" benefit, was another reform option. At the heart of the issue was a desire to expand the provider pool performing case management services by allowing private vendors to be enrolled as case management vendors under MA.

Allowing a separate entity to perform service coordination provides more choice and is intended to address concerns that county agencies may have conflicting interests, since the county also does "gate keeping' and has significant financial interest in the choices made by a consumer. Consumers also stated that some counties lack adequate staff and expertise to meet the needs of consumers. It was felt that private options would enhance consumer choice

and control and would help to alleviate bottlenecks to obtaining case management services at adequate levels.

Expansion of the provider pool would require the separation of gate keeping functions from service coordination, for the reason that duties associated with administering MA must be performed by an agent of the state in order to collect federal reimbursement. Under such a scenario, counties (assuming the current state-supervised county-administered structure) could maintain responsibilities for the gate keeping function. Service coordination, however, could be done by any public or private entity meeting established standards. This particular option was of great interest and supported by many consumer groups.

Several important considerations must be taken into account when reviewing this proposed change. The first consideration is that county agencies generate significant revenue through claims made to MA for the service coordination that is provided by the county. Under waiver programs, the revenue comes fifty percent from the state and fifty percent from the federal government. Under current targeted case management (a covered service under the regular MA program), the revenue is federal financial participation equal to fifty percent of the cost, with counties paying the non-federal share of the costs. Relocation service coordination is an exception to the targeted case management model: fifty percent is state money and fifty percent is federal financial participation.

The enrollment of the private sector as providers of service coordination would significantly affect county agency revenues. Depending upon the scope of the option, it may also require state takeover of non-federal costs or may require that counties pay a share of the non-federal cost without benefit of the federal revenue that it generates.

The second consideration is that the service coordination element of case management must have some relationship back to gate keeping. A private vendor of service coordination would still be required to maintain a connection to the county. The county, in essence, would still need a substantial case management infrastructure but would have fewer revenues to maintain that infrastructure unless the State would agree to take on the financial responsibility for refinancing a portion of the costs related to case management.

The third consideration is that the entities most likely to become vendors of case management service coordination also provide other services (such as residential supports, day program or vocational services, home health care and guardianship). In these cases, there may still be a conflict of interest in helping people access services and providers. Additionally, the state and county hold the financial risk of increased service costs when other services provided are inadequate or unable to meet the needs of individuals. If private case management vendors, responsible to monitor service adequacy, have financial ties to the

agency providing these other services, some means of protecting the financial interests of the state and county are prudent.

Finally, to assure the best protection of consumers and allow for payments to be made, the State would likely need some form of certification process for agencies/entities to become vendors of service coordination functions. Private agencies that currently perform service coordination for individuals with disabilities do so as a subcontractor to the county and not as an independent agency.

Two: Training Case Managers

The Minnesota Legislature modified statutory language in the 2003 session to require all disability case managers to obtain at least 10 hours of training annually. Relative to this, training for these case managers has been given priority by the Department. The goals of training have been to enhance case manager skills, improve consistency in how consumer needs are assessed/managed and to highlight areas of practice that are effective and promising.

There were approximately 13,500 hours of training about disability issues provided to county staff in 2004 by the DHS Disability Services Division. DHS also has invested considerable administrative resources in order to offer a range of options to county staff. The Department recognizes that training will be used more frequently if people have easy and convenient access to information and instructors.

Examples of strategies being used to provide training include:

- *Development of public, Web-based policy and procedure manuals that provide detailed information about each program serving people with disabilities.*
- *Development of Web-based training modules that allow county staff access to training at their own convenience (includes pre and post testing).*
- *Development of computer-supported training modules that are delivered via Web-based streaming or can be played using CD ROM capability.*
- *Access to videoconferencing.*
- *Provision of face-to-face regional and state events.*

DHS will continue to improve and enhance training opportunities specifically focused on the skills needed by case managers.

Three: Implementing a Quality Assurance Framework that Strengthens Case Management Services and Administrative Activities

Quality assurance activities are underway as DHS staff work with external consultants to identify/strengthen the current quality activities into the Home and Community-Based Services Quality Framework recommended by the federal Centers for Medicare and Medicaid Services (CMS). There are seven areas of focus in the quality assurance framework.

The areas are integral to effective case management services practice and administration. The seven focus areas are:

- Participant access
- Participant-centered service planning and delivery
- Provider capacity and capabilities
- Participant safeguards
- Participant rights and responsibilities
- Participant outcome and satisfaction
- System performance

The Department has worked with contractors from CMS to identify the quality assurance and enhancements needed to better manage Minnesota's home and community-based services programs now and into the future. These discussions have resulted in the identification of two areas for more thorough research and development:

- A quality assurance plan relating to program administration: This plan incorporates strategies, which provide better information and analysis of disability service system performance, and is intended to improve business processes at the state and local levels.
- Technology supports that provide tools to the state and local levels in managing services at the individual and the aggregate levels.

Four: Conducting the Phase One Activities Related to Defining Standards and Administrative Streamlining of Assessment Processes

The project currently underway to define and operationalize new assessment processes and to standardize data is integral to the development of feasible and effective case management redesign strategies. Minimally, this process would apply to MA services including home care, home and community-based waivers, institutional services and some non-MA state grant programs. The goals of this effort are to:

- Help the State assure that people will be treated equitably in the identification of needs for services.
- Assure that needs for both basic health care and continuing care are factored into the decisions made in the service plan and authorization of funding.
- Eliminate the multiple, duplicative assessments that must be completed in order for people to access various programs and services.
- Standardize the type of information that the State collects about people with disabilities.

At present, there are varying types of information collected, with limited ability of the state or the county to compare needs and service choices across subgroups. And in some cases, the current assessment process and data collection tools fail to take certain conditions like behavioral disorders or mental illness into full account. DHS would implement a standard process and data collection tool in order to assure that gaps in information are addressed. In this way, Minnesota will be better able to take the steps necessary to plan for future needs. And, more importantly, at the point of service, consumers are better assured that needs are identified and are used to inform and shape the development of the service plans.

To this end, DHS issued a Request for Proposals in late 2003, calling for the development of three products:

- Set of universal standards for assessing the needs of any person with a disability seeking continuing care.
- Common data document that will be used by the State to collect information resulting from individual assessment, including information about individual level of need, individual demographic information, services being sought by individuals and expected outcomes of service.
- Set of recommendations to DHS regarding next steps that could be taken to better assure that there is equitable allocation of resources to individuals based upon information collected in the assessment process.

A contractor was selected and work commenced on the products required by the RFP. The contractor is required to do a thorough review of Minnesota information and data, hold public discussions with Minnesota stakeholders (such as state and county officials, consumers, families, consumer advocates, provider agencies), complete a review of federal requirements for programs relating to people with disabilities and provide a review of national and international research or systems which may have applicability to Minnesota's need.

At the time of this report, work continues. Initial feedback about Minnesota's current assessment processes has been discussed with DHS. The work plan has been revised to expand discussion in three areas:

- Improved assessment of behavioral and mental health needs
- Improved assessment of children's needs and
- Integration of assessment/data collection activities with technology projects already underway or on the work plan for DHS.

As suggested in the above paragraphs, there are other DHS projects that potentially overlap and/or interact with the universal assessment project outcomes and objectives. It makes sense to determine how and where the projects intersect and whether they should be integrated in some way. More specifically, the revised work plan includes:

- Research and presentations on automated assessment and case management systems.
- Research and presentations on person-centered and vocational assessments.
- Developing a plan for integrating the universal assessment process with other current initiatives (such as the on-line application process and automated eligibility system development).
- Developing an implementation plan for automated universal assessment system.
- Exploring long-term financing strategies that would allow Minnesota to capture additional federal funds for this process.
- Review assessments and protocols for Minnesota's mental health service system and provide recommendations on integrating those assessment strategies in the community-based mental health system.

Concluding Thoughts

At the core of Minnesota's disability policy is the concept that services should reflect the needs of individual recipients and that the collective need of recipients guide the funding and development of services. This grass roots approach to managing services means that case management is an intrinsic part of the broader management structure. The case manager both informs this management structure and is informed by the management structure.

The conversion of institutional services to flexible, community-based services has taken twenty plus years. At first, the community structure was so small that it was easy to manage. But in the last ten years, an explosion has occurred in the number and diversity of community alternatives. The management structures have not kept pace and the balance needed between case management and broader system administration has not been maintained. And while case management could be reformed, the central issues have mostly to do with gaps in the overall administration of disability services.

Assuring good management and administration of programs requires continuing investments and a willingness to make changes based upon information and experiences. Over the past two years, DHS has identified a number of improvements that are needed and has begun the process of adapting its management of services to address these shortcomings. Several examples of improvements already made include: *Web-based access for all county agencies of policies and procedures relating to program administration, increased training and technical assistance to county agencies concerning management of services, implementation of revised budget allocation structures to meet policy goals for deinstitutionalization and cost management, revisions to consum*er *directed service options consistent with recommendations of the Legislative Audit Report.* However, these improvements, while useful, do not fully address the needs that continue to exist in managing the broad range of services and consumer interests.

DHS Findings Concerning Case Management Redesign

1. Substantiative reform to case management cannot occur without also addressing other administrative processes and structures of the disability service system.
2. Standardization of case management general practices, protocols, methods of reimbursement and performance outcomes would be helpful in assuring improved equity and satisfaction of consumers, and would assist in creating a more efficient system of coordinating services.
3. Standards regarding case load ratios would provide helpful guidance to assure that there is adequate access to case management services.
4. Processes for assessing needs of individual recipients and for collecting information/data about the needs of people with disabilities is a logical place to initiate some of the needed changes.
5. Options for expanding the case management provider pool to the private sector are not realistic without additional funding.
6. Clarifying the definition of case management to distinguish between administrative functions and the service coordination functions of case management would assist in efforts to expand the provider pool to the private sector or to restructure financing of case management.
7. Challenges to providing good case management frequently are a result of issues related to access to non-entitlement services (waiver programs) and are affected by slot limits and the historical aspects institutional cost comparisons.
8. Consumers vary significantly in their understanding of what services, goods and activities must be covered by public programs and what services, goods and activities may be covered.
9. Common definitions of services across various programs would assist in alleviating confusion and possible duplications in services. Common definitions would also provide a basis upon which to build future discussions about entitlement issues.

10. Technology could assist case managers to collect and coordinate information across the various information systems housing information about recipients with disabilities. For instance, case managers should have access to the vital recipient information in systems such as MAXIS, MMIS, SSIS, Vulnerable Adults, Child Welfare. Current practice requires case managers to access each system independently from the other. This greatly inhibits effective and efficient delivery of case management.