Case Management Redesign

BACKGROUND DOCUMENT

February 2017
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Executive Summary

There are several types of case management services in Minnesota, each with its own provider requirements and funding arrangements. The Minnesota Legislature has directed the Department of Human Services (DHS) to redesign Medical Assistance-funded case management to:

- Increase consumer choice
- Specify and standardize the delivery of services
- Improve quality and accountability
- Streamline funding arrangements

Tribal and county partners, along with stakeholders, have been working with DHS to address these issues, but have not yet succeeded in laying out a unified vision and collaborative redesign plan. The barriers to such a plan include:

- Complexity of the case management system
- High stakes
- Financial implications of changes
- Difficulty of crossing institutional boundaries to create a unified vision

It is a strategic time to re-engage in case management planning. The Centers for Medicare & Medicaid Services (CMS) has asked DHS undertake this work. One issue CMS raised is that components of the rate-setting for mental health targeted case management (TCM) is problematic. A second issue is related to the limited choice of waiver case management to counties.1

This document describes the 2016 efforts to inform Minnesota’s re-engagement in case management planning. This work includes:

- Interviews with 23 key participants in early 2016 to gather opinions about past case management planning accomplishments and the barriers to forming an integrated vision across all types of case management.
- Establishment of a small workgroup of partners and stakeholders to advise DHS during the pre-planning phase. The workgroup includes representation from people who receive case management services, advocates, Tribes, counties, health plans and DHS staff.
- Creation of four background documents:

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1 On 12/18/13, CMS sent a letter to DHS saying that the rate-setting for mental health targeted case management is problematic because 1) the bundled payments make it possible that payments for some services that are not covered by Medicaid (for example, room and board) could be made; 2) county-negotiated rates (to private providers) do not demonstrate a uniform, state-wide rate setting methodology approved by DHS; and 3) federal law requires direct payment to the provider of the service and the current State Plan’s method for dividing up payments among a team of contracted vendors may not meet that requirement.
1. A summary of past legislative reports

2. A draft vision and values for the planning process based on past work and a summary of three focus groups

3. Past reports, and a preliminary discussion of equity as it relates to case management planning

4. An overview of the funding structures for case management

- Collection and circulation of stakeholder position statements on case management.
- Circulation of the four background documents and collection of stakeholder feedback through an online survey.
- Formation of a DHS Leadership Alignment team among senior DHS leaders to review stakeholder feedback and achieve DHS division alignment about the possible scope and direction of case management planning.
- The inclusion of Tribal members and representatives from Minnesota Association of County Social Service Administrators (MACSSA) in the Leadership Alignment team in order to ensure joint leadership and oversight for case management redesign.
- DHS will draft a proposed roadmap for CM redesign planning.
- Scheduling a workshop for January 2017 to summarize results from previous planning efforts and gather feedback on vision and goals for case management services.

This document summarizes these activities and serves as the background document for the case management redesign work. It includes proposed vision, goals, principles and service characteristics for the next phase of case management planning.
CASE MANAGEMENT REDESIGN: COMPLETION OF THE INFORMATION-GATHERING PHASE

I. Introduction

DHS submitted legislative reports on the redesign of Minnesota’s case management system in 2014, 2013, 2011, 2008, 2007, 2005, 2003, 2000, 1994, 1993 and 1991. These reports provide historical perspective on the significant improvements in Minnesota’s service delivery system in the past 25 years (for example, increased federal funding for case management, broader availability of case management services, and streamlining of the assessment and intake function). They also illustrate the state’s continued struggle to create an integrated, person-centered approach to case management across the many populations that receive case management services. The current system is the result of decisions made in many different historical contexts by a variety of different players with different priorities and different policy tools. Minnesota’s desire to bring in federal dollars to support case management has greatly influenced the current system.

DHS determined in 2015 that it would re-engage in case management planning. To inform planning, recommendations from several past legislative reports and workgroups were reviewed. Also, interviews were conducted with 23 participants in past planning in order to recommend a design for the next stage of planning (see list of interviewees in Appendix I).

The review and interviews led DHS to establish an “information-gathering” phase. One goal of the information-gathering phase is to work through identified barriers which have hindered past planning efforts. Another goal is to complete pre-work that will set the stage for the development and implementation of a planning roadmap for case management (CM) redesign. This phase includes the following objectives:

- Analyze past work so that DHS can use it to identify points of agreement and lay out issues we still need to resolve
- Strengthen relationships with partners and stakeholders through respectful engagement and clear communication about how we are using their input
- Facilitate DHS leadership alignment in order to develop a planning roadmap for CM redesign with agreement on a unified vision.

This document summarizes these activities and serves as the background document for the January 2017 workshop. It begins with a very brief overview of Medicaid-funded case management in Minnesota, then summarizes the recommendations from several recent legislative reports on the subject. It then proposes a roadmap for the next phase of case management planning, including draft vision and principles to guide the work. DHS will summarize the roadmap at the January 2017 workshop and revise it based on the feedback received.

II. Brief Overview of Medicaid-Funded Case Management in Minnesota

Case management helps people gain access to and navigate services and community support systems including:

- Physical health
- Behavioral health
- Employment and education
- Social services
- Financial supports
- Housing
- Others
Targeted case management (TCM) services are designed for a distinct group of people who receive services such as children with severe emotional disturbances or adults with serious and persistent mental illness. Case management has existed as a separate, reimbursable class of Medical Assistance services since 1986. Congressional amendments initially made TCM services a payable class of Medical Assistance service when furnished as part of state waiver programs under §1915 of the Social Security Act. Congress subsequently amended Medicaid to permit states to furnish TCM services as a covered service regardless of whether coverage was offered in connection with a waiver program.

- Adult mental health TCM: Adults with serious and persistent mental illnesses can receive case management through the adult mental health TCM service.
- Children’s mental health TCM: Children with severe emotional disturbances who are enrolled in Medicaid or MinnesotaCare can receive case management through the children’s mental health TCM service. Some counties also provide this service to children who are not Medicaid eligible.
- Vulnerable adults and developmental disabilities TCM: Adults who meet criteria for Rule 185 and who do not already receive waiver-funded case management can receive case management through the vulnerable adult and developmental disabilities TCM service. Vulnerable adult TCM services are for vulnerable adults in need of protection as defined under Minnesota Statutes 626.5572 who need service coordination to attain or maintain living in an integrated community setting.
- Child welfare TCM: Children under 21 years old who are enrolled in Medicaid or MinnesotaCare and who meet at least one of these criteria are eligible for child welfare TCM: at risk of out of home placement or are in out of home placement, at risk of maltreatment or experience maltreatment, or are in need of protection or services.
- Relocation services coordination TCM: People in hospitals, nursing facilities, ICF-DDs, and regional treatment centers can receive case management to support transition to other settings.

Medicaid also pays for case management under a variety of other services and programs in Minnesota.

- Waivered case management: Case management can be provided in home and community-based services (HCBS) waiver programs under §1915(c) of the Social Security Act. In Minnesota, people enrolled in an HCBS waiver program are required to receive case management as one of the covered services. People with disabilities who receive services under the following waivers are entitled to case management:
  - Community Alternative Care (CAC)
  - Community Access for Disability Inclusion (CADI)
  - Developmental Disabilities Waiver (DD)
  - Elderly Waiver (EW)
  - Brain Injury (BI)

Older adults who receive services under Elderly Waiver (EW) are entitled to case management. Older adults who are enrolled in Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) receive their EW services through a managed care organization.

People who receive these waiver programs who also receive consumer directed community supports (CDCS) services can receive optional flexible case management and support planning. Individuals over 65
years old who are at risk of nursing home placement and are not yet financially eligible for Medical Assistance can receive HCBS through the Alternative Care (AC) program, which is an 1115 waiver demonstration project. Case management is one of the covered services under AC.

- Rule 185: People with developmental disabilities or related conditions can receive Rule 185 case management.

It’s clear from this list that there are many types of case management, each with its own “target” population and requirements. Perhaps the most significant distinction among the several types is whether the case management is voluntary or whether it has been ordered by a court.

Most forms of case management are voluntary; the person who receives services chooses case management services. However, child welfare-TCM and case management for people who are committed may be ordered by the court. By the order, the case management is involuntary, a requirement of the court or law. Vulnerable adult-TCM may be court-ordered in order to protect a vulnerable adult.

This distinction affects many aspects of how the services are provided, paid for, and how they are experienced by the people who receive the service. The legislative reports reviewed in the following section have mostly focused on the voluntary forms of case management. Further planning will have to consider both voluntary and involuntary types.

Case management services are provided through Tribal and county agencies and managed care organizations. This includes:

- Fee-for-service Tribal-provided case management services
- Fee-for-service (FFS) county-provided case management services
- Fee-for-service county-contracted case management services
- Capitated managed care organization-contracted case management services.

Some programs provide care coordination, which includes activities similar to case management but include both acute care and long-term services and supports. People enrolled in MSHO and MSC+ are assigned a care coordinator regardless of their service needs or waiver status. Since 2009, mental health TCM has been included in the benefit set for those who enroll with managed care organizations under Medical Assistance.

II. Medicaid as a Funding Source for Case Management

The federal government’s Medicaid program is a significant payment source for health care services (which includes case management services) to Minnesotans with low income. In 2014, Minnesota (state and counties) spent $10.4 billion on Medical Assistance programs and administrative costs. We received $5.76 billion in federal Medicaid reimbursements. The Affordable Care Act charged CMS to achieve the “triple aim” of improving population health, improving the experience of health care for individuals and controlling health care costs. In the document titled, “CMS Strategy: The Road Forward, 2013-2017”, CMS set the following objectives:

- Expand insurance coverage
- Strengthen the private insurance market
- Establish affordable insurance marketplaces
- Protect consumers of health care services
- Implement payment arrangements that reward the outcomes of care rather than the volume of care
• Improve the integration and coordination of care
• Reduce hospital admissions
• Reduce disparities in health care outcomes
• Promote the use of health information technology in health care
• Introduce system cost controls
• Improve program integrity
• Support innovation in health care delivery and payment

From the federal perspective, Medicaid is a key mechanism to incentivize states to implement federal reform efforts (such as the shift from institutional to community-based care and the promotion of care coordination for people with chronic health conditions). Minnesota’s reform efforts are generally in alignment with the federal direction. The state has taken advantage of CMS opportunities, including additional federal funding.

However, there have been downsides to this strategy. We have created a service system that is prohibitively complicated. It has layers of disjointed and overlapping funding and rules that can confuse even the most dedicated policy leader. Past efforts have highlighted the complexity and called for integration and simplification, but the scales of political, economic and organizational realities prevented redesign at a significant level. We truly have created a system that is too complex to succeed and too big to fail.

Redesigning case management is an example of this complexity. Attempts at redesign have been going on for 20 years, with improvements but no major redesign or reform. When participants in those efforts were interviewed about the barriers to progress, the most often-mentioned barrier was the failure of DHS to develop a unified vision for case management that leaders across DHS would commit to. The lack of unified vision is the result of very real differences in how case management figures into the funding and policies of particular divisions. It is a microcosm of the differences that exist across all Tribal, county partners and stakeholders affected by case management. The information-gathering phase has given DHS, partners and stakeholders the opportunity to acknowledge this reality and work toward the creation of a unified vision.

IV. Review of Past Legislative Reports

This section reviews case management legislative reports that were completed in 2014, 2013, 2011 and 2008, as well as the Minnesota Olmstead Plan. To organize the volumes of information provided in those reports, this section is organized loosely around the topics identified by the legislature in the 2013 directive to DHS to make recommendations on case management redesign:

1. Definition of case management
2. Case management provider qualifications, which may include establishing a licensure or certification process
3. Caseload size
4. Outcome measures for case management services to assure continuous quality improvement
5. Choice of case management services provider
6. Informed choice for people receiving services
7. Rates that are transparent and consistent
8. Informing people about the case management services they receive
Because No. 5 and 6 are intertwined, they are discussed together in Section E. Because No. 8 is quite narrow in scope and was not discussed extensively in the 2014 legislative report, it is not reviewed below. For each of the following six sections, the section begins with background information about the topic. It then identifies the policy issues involved, lays out areas of agreement from past planning work, summarizes past recommendations, and points out questions specifically relevant to equity concerns. This analysis is driven by the legislature’s vision of a more integrated, standardized approach to case management across all types.

A. Definition of Case Management

Background

Minnesota’s case management system has different expectations of a case manager depending on the type of case management provided and the focus of the services. For example, relocation case management “assists individuals moving from nursing home facilities to more independent living settings.” That is a definition unique to that type of TCM.

The varying definitions allow for differences among services, including length of service (based on the needs of the person who receives services) and voluntary vs. involuntary services. The legislature has directed DHS to propose an integrated vision for case management to help people who receive services understand what they can expect from case management and help reduce duplication of services. Developing a more uniform definition across types of case management could help achieve that goal.

CMS generally defines case management services as activities designed to help the person gain access to needed health, social, educational, vocational and other necessary services and supports. In Minnesota, the 2013 legislative report recommended the following as a service definition for all types of case management services (except for child welfare TCM and vulnerable adult TCM, as for those two services, the federal definition applies):

“Case management is a service that provides a person with access to assessment, planning, referral, linkage, plan monitoring, coordination and advocacy in partnership with the people we serve and their family. A case manager assists with access to and navigation of social, health, education, vocational and other community supports and services based on the person’s values, strengths, goals and needs.”

The activities identified in this definition are based on current state and federal definitions:

- Assessment: Written assessment based on discussion with the person who receives services and his or her support system and providers; an assessment of the needs, strengths, skills, culture, safety considerations, current resources and supports, and goals. Periodic updates are made to the assessment.
- Plan: Written plan developed with the person receiving services that describes his or her goals, services and supports needed; steps to be taken to accomplish and support the goals, and responsible participants. Periodic updates are made to the plan.
- Referral and linkage: Connections to services and supports to accomplish the goals of the person receiving services.

2 This section focuses on the statutory and regulatory terms used to define case management, recognizing that people receiving services would probably use different words to define case management, such as: “My case manager is the person who helps me find housing, get my medications, and take care of my medical issues.”
Monitoring and coordination: Monitoring of the effectiveness of the plan and services and support to assist the person receiving services to accomplish the goals. Coordination with service providers and community supports and resources, with or on behalf of the person receiving services to assure the success of the plan.

Advocacy: Advocacy, with or on behalf of the person receiving services, to intervene in case of problems with miscommunication, access to services and supports, discrimination or lack of resources.

**Issues**

As part of case management reform, is it possible to construct a common platform defining all case management service types and activities and add, as needed, additional services and activities that are specific to each type of case management? If a common platform is possible, it could provide the basis for common quality measures, case manager and provider agency standards and certification, and rates and cost assumptions and models.

- Would or does CMS approve of moving beyond the “service-broker” model toward more intensive models of case management services that include skills training or rehabilitation activities by the case manager? This may create efficiencies in service delivery, particularly in parts of the state where there may not be sufficient psychosocial rehabilitation services. Assertive Community Treatment is one model of mental health case management that includes psychosocial rehabilitation, psychotherapy, crisis prevention and medication management services in one multidisciplinary team approach.

- Case management services do not currently include helping people and their informal support system to acquire the skills to become their own case managers. Should case management be broadened to include this assistance for those interested in, and capable of, learning such skills?

- Case managers and people receiving case management services have complained that case managers face too many documentation requirements—too much paperwork, and that that interferes with other case management responsibilities. Does case management redesign offer the opportunity for administrative simplification while assuring quality of services and integrity of payment?

**Areas of agreement**

- A core definition and set of service components has been proposed that could apply to all types of case management. This might be the basis for creating a common platform for case management services. On this platform there could be recognition of the differing target populations to be served, the service activities unique to each type of case management, and the intensity of services involved.

- There is shared recognition that the working relationship between the people receiving services and their case managers is at the core of quality case management.

- There is recognition that differing parts of the state operate differently and that is important to ensure both flexibility and access to services across the state.

- There is frequent discussion of the potential to create “tiered” case management services with varying and flexible intensities of support. This could include a step-down, less intensive case management service level for continued support when people no longer need traditional case management services.
Regardless of redesign, there is a need to update statute and administrative rules to clarify and to reflect changes in person-centered language, Tribal authority, integrated care and outdated language.

There is a recognized need for more direct input into reform and redesign by people served, their families and case managers.

Past recommendations

- Statutes should adopt a common definition of case management.
- A common basic set of roles and activities in all case management services should be defined, with specialized roles and activities added as needed for specific types of case management services or populations.
- People receiving case management services should be given the case management definition and a list of activities they can expect to be provided by their case managers.
- DHS should require case managers to discuss their role with the people they are serving, including expectations, boundaries and activities they may perform on behalf of the people.
- Information that is given to the person should:
  - Be in a standardized form as outlined by DHS.
  - Be given to the person receiving services at the start of the service.
  - Describe the service activities, responsibilities and role of the case manager.
  - Include descriptions of activities that will involve direct contact between the case manager and the person receiving services and those that are completed on the person’s behalf to support the service plan.
  - Describe the role and responsibilities of the person receiving case management.
  - Include description of appeal rights and the process to file an appeal.
  - Be provided and reviewed at least semi-annually.
- If possible, expand the definition of qualifying case management services to include helping prepare people receiving services or their natural supports to fulfill case management functions. Currently, CMS’s model of TCM may not permit case managers to provide this type of skills instruction to a person.
- Update mental health TCM statute to reflect recent changes (for example, mental health TCM being a covered benefit in Minnesota Health Care Programs) and to address gaps in current language (for example, the role of Tribal authority as it relates to mental health TCM).
- Further study the issue of duplication of services.

Equity considerations

- In assessments, what could be done to ensure that individuals’ cultural beliefs and practices are sufficiently considered?
- How can Minnesota ensure that there are enough case managers to provide culturally-specific case management services to everyone who needs them?
B. Case Management Provider Qualifications

Background

This summary addresses case management provider standards at two levels:

- Standards and qualifications for individual case managers
- Standards for case management service agencies

Individual Case Manager Standards

The baseline educational requirement for case managers is generally a bachelor’s degree in social work, nursing, psychology, sociology, habilitation and rehabilitation services, or closely related human services field. To be a case manager for some types of case management there are requirements of past work experience with the targeted populations; for other types there is no requirement of past work experience. Although many case managers may have a professional license, such as a licensed social worker, there is not a state-wide standard requiring professional licensing of case managers.

There are varying requirements for initial training and supervision. Mental health TCM requires 40 hours of initial training for new case managers who do not have 2,000 hours of supervised experience in delivery of mental health services, and initial supervision of an hour a week. Case managers with the 2,000 hours of supervised experience must receive 38 hours of supervision per year and 30 hours of continuing education every two years. There may also be specific requirements for qualifications or license of the supervisor; for example, mental health TCM requires clinical supervision by a licensed mental health professional.

There are variations regarding continuing education requirements as well. For example, case managers who work with people receiving services through the Developmental Disability waiver must complete 20 hours of continuing education each year, but case managers for other waivered services do not have a continuing education requirements.

Tribes, counties, and managed care organizations may set higher levels of qualifications for their contracted case management agencies’ staff than the minimum state standards noted above.

There is a shortage of qualified and experienced case managers in some areas of the state. Creating “career ladders,” pathways for non-degreed individuals or individuals without extensive prior work experience, is one possible solutions. An example is mental health TCM’s para-professional case management associate (CMA) position. CMAs assist case managers with implementation of service and support plans. CMAs who acquire more

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3 Case managers who are new to adult mental health TCM are provided with initial web-based training. These online modules provide them with a foundation of the knowledge and skills required to provide case management services. This model for training is recommended for all case management types. The training should enhance case management skills, improve consistency in how people’s needs are met and highlight areas of practice that are effective and promising. Each case management type could have additional specialty training. Case manager training should include information about services and supports that may be available to the persons receiving services in order to ensure case managers have broad knowledge to support their role in referral, advocacy and access.
than three years of experience can then be qualified as case managers. The CMA position does not require a bachelor’s degree, but requires additional training and supervision.

The American Indian Mental Health Advisory Council recommended that a study be completed to establish comparable but alternative qualifications for case managers serving members of Tribes or members of diverse communities. Tribes have the authority to establish comparable but alternative qualifications for individual providers. Mental health TCM allows for comparable but alternative qualification for culturally skilled case managers to serve immigrant populations.

Case Management Provider Agency Standards

There is no overarching statewide certification or licensure for agencies that provide case management services. In general, case management providers must be enrolled MA providers and meet general MA provider eligibility standards, but these are not specific to the service of case management.

When provider agencies contract with counties and managed care organizations to provide case management, there are limited statewide standards for the service. Expectations of those provider agencies are identified in the individual contracts that are held by the lead agency (e.g., a Tribe or county), in compliance with state statute and administrative rule. Tribes have the autonomy to credential mental health professionals that meet or exceed state standards. Tribal governments can license American Indian programs that provide substance use disorders and mental health services.

DHS has implemented provider certification processes for several mental health services:

- Adult mental health rehabilitation services
- Assertive Community Treatment
- Children’s therapeutic services and supports
- Youth Assertive Community Treatment
- Dialectical behavior therapy

The initiative for home and community-based services (HCBS) waiver provider standards also creates a system that standardizes provider qualifications. Some specific examples of how provider agencies are certified as providers include:

- Child welfare TCM defines the certified provider as a Tribal or county child protection agency that has met (one time) certification standards. Case managers are employed or contracted with the certified provider and meet education and training standards. Contracted provider agencies fall under the certification of the county or tribal child protection agency.
- For mental health TCM (adult and children), the provider agency must be the Tribe, county, or managed care organization, or be an agency that has a contract with one of those bodies. DHS enrolls the provider agency based on evidence of the contract. There is no certification or licensing of the provider agency. Counties, individually and as a group, have processes for oversight of services and quality assurance.

Issues

- Should there be additional standards or certification requirements for individual case managers or for agencies providing case management services?
If additional standards are desired, how will both the certifying bodies and the case management provider agencies be funded and staffed to maintain an ongoing certification or licensing process?

The difficulty of finding affordable supervision is one barrier that aspiring case managers encounter. How can Minnesota best address this barrier?

Should DHS establish an electronic provider reporting portal for efficiencies of information reporting and licensing or certification processing?

How should certification and licensing functions relate to the contracting processes that Tribes, counties, managed care organizations use to monitor quality of case management services? Are there conflicts or duplication that could be eliminated?

What is the most efficient and effective way to provide new case managers with required training?

Are there additional topics or specialized information that should be added to existing training requirements?

What additional strategies can be deployed to address the shortage of qualified, experienced case managers? Particularly, how can Minnesota ensure the availability of culturally-specific case management services?

Areas of agreement

- Case management provider agencies should be certified or licensed. This will create consistency in the service across the state. It will assist DHS to:
  - Ensure access to consistent service
  - Verify compliance with case management service standards
  - Implement quality outcomes and measures
  - Provide general and targeted technical assistance and support
  - Provide people with a resource to resolve disputes or complaints
- Individual case managers should not be certified or licensed at this time.
- Case management services accountability and quality are wanted by all.
- Tribal government should establish the proper licensure or certification to determine culturally-specific outcomes, qualifications and standards for each type of case management service.

Past recommendations

DHS should:

- Use the current educational standards for case managers. The agency should also consider alternative but comparable qualifications to assure cultural competence and accessibility of the service.
- Require foundational training for case managers on the definition and activities of their role.
- Require continuing education for case managers. These requirements would not be in addition to, but complementary of, their professional licensure continuing education if applicable.
- Explore the best options for case management providers to be certified or licensed. This would include identifying the costs and sources of funding for a certification or licensing process.
Case Management Redesign: Completion of the Information Gathering Phase

- Develop specific performance measures and outcomes for the service of case management.

**Equity considerations**

- To increase the availability of culturally specific providers and cultural competence among all providers, Minnesota could expand the development of comparable but alternative sets of individual case manager qualifications for aspiring case managers who are members of diverse and under-represented communities. Examples include the mental health TCM immigrant case manager qualifications and Tribe-determined comparable but alternative qualifications of providers serving Tribal members.

- To increase communities of color members’ access to case management services and to improve their health outcomes, consider the development of culturally-specific provider agencies. These provider agencies would be contracted, licensed or certified to serve targeted communities of color, provide additional outreach to those communities, and employ staff who are members of those communities. Higher reimbursement rates could compensate for the additional service and data reporting requirements of the culturally-specific provider agency.

- Minnesota should implement additional strategies to ensure that English-as-a-second-language and interpreter services are accessible in a timely way to all people receiving case management services who need them.

- Consider, define and fund the role of cultural consultants.

- Additional strategies for ensuring the cultural competence of all case managers are needed. The costs and time-demands of training should be included in considerations of additional training requirements.

**C. Caseload size**

**Background**

Reasonable caseloads permit case managers to be proactive in meeting people’s needs. If caseloads are too large, case managers only have time to react to someone’s crises; as their responsiveness diminishes, so does the effectiveness of the service. Case managers commonly report that their high caseloads prevent them from assisting the people they serve in all of the ways that they should.

For most types of case management, there are not statewide standards for caseload sizes and each provider agency determines appropriate caseload sizes. Standard caseload sizes are currently in place only for children’s mental health TCM (15 children to one full-time equivalency case manager) and adult mental health TCM (30 individuals to one full-time case manager).

There are several factors what would affect appropriate caseload sizes:

- The intensity and scope of the services of a specific type of case management.

- The intensity of individual needs within a specific type of case management could also vary. It may be possible to standardize tiers of service intensity that correspond to specified caseload sizes. Payments could be made based on an assessment of individuals’ service needs, or reimbursement could be based on actual services provided (so more services provided equals more reimbursement, which would support lower caseloads).
Some individual case managers may provide more than one type of case management (often in smaller rural counties) because of case manager expertise or small number of eligible individuals for a specific type of case management. Also, some people receiving case management services are eligible for more than one type of case management. To determine appropriate case load sizes, the concept of mixed caseloads need to be considered.

Costs could increase. If lower caseloads were established in statute or administrative rule to improve the quality of services, significantly more case managers would need to be employed and reimbursement rates would need to increase to fund the lower caseloads. This would have cost implications for the state and other payers.

The use of team approaches or case management assistants also complicate the determination of appropriate caseload sizes: a case manager who has a case management associate should theoretically be able to sustain a higher caseload than one who does not have an associate, all other factors being equal.

The caseload size of supervisors and clinical supervisors is similarly challenging. Some types of case management have standards about the frequency and oversight activities of the supervisor of case managers in order to provide direction when needed to case managers and to ensure quality of assessments and plans. Supervisors’ and clinical supervisors’ standards may include minimum frequency of meetings with the case manager, review of charts, sign-off on assessments and plans, and specific qualifications of the supervisor. For example, mental health TCM case managers must receive at least monthly supervision from a licensed mental health professional. Some supervisors report being responsible for the clinical oversight of hundreds of people receiving case management services, and questions have been raised about the possible need for training standards for supervisors.

**Issues**

- Increased service cost implications is a major factor when considering caseload size standards. It may be difficult to set a single caseload standard across all types of case management services, but it may be possible to establish common assumptions and logic that could be implemented across different types of case management.
- Lowering caseload sizes could exacerbate the already challenging shortage of qualified and experienced case managers, particularly in certain regions.
- Lowering caseload sizes for supervisors and clinical supervisors could similarly exacerbate the shortage of mental health professionals in most parts of the state.
- Would it be possible to improve efficiency of paperwork and other administrative functions (for example, through better work processes or the use of telehealth applications) in order to give case managers more time to work directly with people?
- If people receiving case management services or their natural supports were trained to fulfill some case management functions (where appropriate), could case managers have more time to assist other people with circumstances that truly demand their skills and training?
- It will be difficult to determine standardized caseload sizes given that individual case managers sometimes provide multiple types of case management and that some people receive multiple types of case management simultaneously.
• The particular activities that case managers need to provide can significantly affect the caseload size that a case manager can sustain. CMS’s “broker model” of case management services does not recognize that some regions lack the necessary services and supports to refer people to, so case managers need to try to fill in where they can or they spend inordinate amounts of time trying to locate providers.

**Areas of agreement**

There is agreement that:

- Requiring some limited CEU training in supervision would be helpful to support the consistency of case management services provided statewide. If possible, these CEUs should be designed to qualify as CEUs for the continued professional licensing requirements of supervisors.
- DHS should maintain current mental health TCM caseload standards.
- DHS should explore addition of case management services focus to include building an individual and his or her natural supports’ “self-case management” skills.
- Most stakeholders think that establishing caseload standards for all types of case management should be studied further before potentially proceeding with any changes. Mental health TCM stakeholders agree that caseload standards are an important service quality standard and did not recommend changing the standard.

**Past recommendations**

We should:

- Maintain current adult and children's mental health TCM caseload standards.
- Continue to study the value of establishing caseload standards for other types of case management.
- DHS should develop training for supervisors, clinical supervisors, and case managers on supervision standards, documentation, and “best practices” in supervision.
- Further study is needed before establishing caseload sizes for supervisors.
- Consider options for models of case management that provide more intensive services or include not just “brokering services” but life skills training or rehabilitation services.

**Equity considerations**

- Does providing case management services to diverse populations have an impact on caseload size considerations? For example, are greater outreach efforts required?
- Should supervisor or clinical supervisor training require training in equity and cultural competence?

**D. Outcome Measures**

**Background**

There are limited statewide quality outcome measures for individual case managers or provider organizations regardless of case management service type. When assessing case management services, the current practice has
been to describe program enrollment, caseload figures, financial billing and reimbursement for services. There is also limited regular monitoring of case management service standards in Medicaid-funded programs although managed care organizations that contract with Minnesota Health Care Programs are required to regularly monitor their case management providers to ensure compliance with service standards.

In 2005, the DHS Continuing Care Administration began the Waiver Review Initiative. This initiative completes regular audits of lead agencies’ administration of home and community-based services (HCBS) waivers, which include case management services. The goals of this initiative are to monitor compliance with state and federal requirements, identify promising practices, and track local improvements. Quality measures could be developed using the data from the Waiver Review Initiative that would be useful across other populations that utilize case management services.

The Continuing Care Administration will conduct participant experience surveys in the future. In addition, the State Quality Council is working in partnership with the Community Supports Administration to recommend enhancements to the Long-Term Services and Supports system. Including case management would add additional data to assist in developing performance measures. The Minnesota Olmstead Plan also includes a limited number of specific case management goals and outcome measures to be reported.

In children’s services, there are several systems for measuring outcomes. The Minnesota Child and Family Services Review system conducts audits with county social services periodically. This review system mirrors the federal system for auditing outcomes for children in Minnesota. The data and research unit of DHS publishes an annual Child Welfare Data Report.

**Issues**

- It is difficult to establish and track outcomes measures when we lack a common or systematic definition of the service of case management and the activities it comprises. Without such measures, the system lacks clear expectations for case managers, case manager provider agencies, and people receiving services and their families. Accountability and quality improvement can suffer as a result.
- The logistics and work processes involved in establishing, measuring and reporting outcomes are challenging. Right now Minnesota has multiple reporting systems that could include case management measures reporting, or a single reporting system modified for all case management reporting could be developed based on resources and long term goals.
- It’s important to balance the demands of an outcome tracking system with the value of the information that it provides. Most stakeholders acknowledge that case managers are already handling crushing amounts of paperwork; instituting outcome measures is likely to increase the amount of reporting that is added to case managers’ duties.
- Quality measures and results should be accessible to people receiving case management services and people who provide the service, so Minnesota needs a means for communicating outcomes to both professional and lay audiences.

**Areas of agreement**

- Outcomes and measures should include person-centered outcomes that are quality-based, and include consumer satisfaction and experience of care. Outcomes and measures should not just count people receiving the service or units of services provided.
DHS needs a current, real time provider reporting system for measurement and information tracking. Measuring results of individual providers could assist people in choosing providers, but this will require measures that can take into account the differing populations that different providers serve. This has been a significant challenge in establishing physical health care outcome measures.

Providers of case management services submitting measures to a provider reporting system should receive feedback from that system about the provider’s outcomes in comparison to statewide provider outcomes in order to be useful in the provider’s continuing quality improvement process.

Past recommendations

- DHS should establish a minimum set of outcomes and measures common for all forms of case management. An example measure is “the percentage of people receiving case management services who receive an annual physical examination.”
- The outcomes should also include a minimum set of measures that are specific to each type of case management service and the population targeted. An example for adult mental health TCM is “reduction in psychiatric hospitalizations or re-hospitalizations.”
- DHS should develop a provider electronic system for case management information and measures for all providers of case management services. Funding for the development, maintenance, and additional department staff will be needed to develop and maintain this system.

Equity considerations

- How can we ensure that standardized case management services outcomes measures and continuous quality improvement processes provide meaningful information to individuals of diverse communities and their providers?
- Will we need specialized processes for gathering experience-of-care, satisfaction, and outcomes information from individuals and families of diverse communities?
- How should diverse communities be involved in the development of outcome measures?

E. Informed Choice of Case Management Services Provider

Background

CMS, the Minnesota Legislature, and the Minnesota Olmstead Plan all say that people receiving case management services should be able to choose the provider of those services and that they should be informed of their options before making that choice. The particular arrangements under which case management services are provided can have a significant impact on choice of provider. For example, some counties provide mental health TCM using their own staff, while others contract with another provider. Some counties use a combination of both methods. A large urban county may offer a wide range of choices of provider while a small rural county may be the only provider in the county. The breadth of providers available through managed care organizations also can vary and is influenced by multiple factors.
CMS includes person-centered service planning and delivery in the home and community-based services (HCBS) quality framework. Having a broad network choice of case management providers is an important element of a system that supports self-direction and independence.\(^4\)

Choice of provider is further complicated by changes in statute that have separated the administrative, eligibility and gatekeeping functions of case management from the provision of case management for people receiving waivered case management services. In part, the MnCHOICES assessment process is facilitating this change, and will take the place of other assessments that currently are used to determine eligibility for waiver programs, the Alternative Care program, personal care assistance and private duty nursing and some state grants. An assessor gathers information and makes eligibility determinations related to institutional level of care, programs and services, and develops an initial community support plan. The case manager then uses the MnCHOICES assessment and the community support plan to facilitate the support planning process with people receiving services, and finalizes the coordinated service and support plan. The assessment process thus poses a level of decision-making that affects the person’s access to services and possibly of specific case management provider.

Choice of provider is constrained for people who receive case management services due to civil commitment or other court order. For example, child welfare TCM is designed so Tribal and county child welfare agencies are the only agencies certified as providers, because they are the authority for child protection (although counties occasionally contract with private agencies for the work).

**Issues**

- There are several counties with a single provider of fee-for-service or managed care mental health TCM services. Although this is a limitation on consumer choice, in a small county there may be insufficient eligible individuals to financially support multiple case managers or multiple provider agencies.
- The current case management funding structure includes significant levy dollars and each county, as the local mental health authority, is responsible to pay for services for people whom are under-insured or uninsured and manage the waiver budget. Requiring choice could create complexity for counties who need to ensure they have the capacity to serve these population.
- The choice requirements that CMS might make when Minnesota submits Medicaid State Plan Amendments are not totally predictable. CMS has identified choice as a principle and it may apply specific requirements related to choice of provider as part of its approval.
- The process for ensuring that people who receive case management services are adequately informed about their case management provider choices must still be determined. Implementation of the Minnesota Olmstead Plan is hastening the development of specific guidelines for informed choice.

**Areas of agreement**

- All things being equal, choice of provider is a good principle to pursue because it will contribute to a productive relationship between the person and provider of case management services. However, there are practical limitations that need to be addressed, like the small number of providers in rural areas, the economies of scale involved in providing the service and involuntary case management.

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\(^4\) See Minnesota Statutes, section 256B.0911 for a description of a community support plan, and sections 256B.0913, 256B.0915, 256B.49 and 256B.092 for a description of a coordinated service and support plan.
Implementation of the Minnesota Olmstead Plan includes consumer choice and options to inform a person about choices and decisions concerning services.

- It would be possible to develop standard, printed orientation materials defining services, summarizing common questions and answers, and explaining a person's rights and responsibilities, the appeals process, choice of provider and other information for distribution to all applicants and people receiving services as part of the intake process and annual review.

**Past recommendations**

- DHS should develop procedures to ensure people are provided meaningful choice of case management service providers to ensure people receiving case management are able to choose a provider that will meet their needs. They also should be allowed to change providers if they choose. This includes providing them information about:
  - Provider agency mission and values
  - Geographic region of service
  - Availability of bilingual or bicultural case managers
  - Ratings, measures, and provider report cards that include personal service experience and satisfaction ratings
- DHS should develop standardized information about case management to be given to people as they inquire about services or are determined to be eligible for a service.
- DHS should require a semi-annual evaluation of case management services so that changes can be made to the service plan if needed.
- DHS should continue to analyze what is needed to fully develop choice and identify needed changes to the structure or provision of case management. DHS should work with stakeholders to ensure these changes are made in partnership.
- People receiving services should be able to switch case managers at least once without having to offer explanation or justification, at least in voluntary situations.

**Equity considerations**

- How will DHS ensure that members of diverse communities are included in the input process related to choice?
- How should DHS identify and address any institutional barriers that impact access to, and the cultural competence of, case management service providers?
- What is the best way to ensure that people who receive case management services are given information about the availability of case management providers who are culturally competent or culturally specific?
F. Rates that are Transparent and Consistent

Background

The complexity of case management provision in Minnesota is matched, if not exceeded, by the complexity of case management funding. This section provides a brief introduction to the existing funding structures, recognizing that it will require significant additional formulation to lay out the intricacies of the funding system. Appendix II contains a more in-depth discussion of case management rate-setting issues that could help inform discussions of this topic as case management planning moves forward.

Targeted Case Management

TCM is defined in §1915(g) of the Social Security Act, and permits states to target a subset of Medicaid beneficiaries to receive the service as a state plan benefit. TCM is a state plan service and an entitlement to people who are receiving MA and eligible for the service. The rate that is paid for TCM services depends on who provides them (county or contracted provider) and whether the person is covered by a fee-for-service or managed care. These processes are used for rate setting for TCM:

- When counties provide case management services themselves, DHS sets cost-based rates using “time studies” that attempt to identify and allocate counties’ costs to provide case management services. The rates vary widely from county to county. The counties pay the state share of the cost.
- When counties and Tribes contract with case management agencies to provide case management services for their residents, they negotiate rates for those services using whatever basis they agree upon with the provider. The counties pay the state share of the cost.
- When managed care organizations contract with counties or providers for case management services, rates are established by the managed care organization. The State of Minnesota pays the state share of the cost as part of the capitation payment that is negotiated annually with the managed care organization.
- When managed care organizations contract with other agencies for mental health TCM case services (the only type of TCM that is not just fee-for-service), the rates are negotiated between the managed care organization and the providing agency. The State of Minnesota pays the state share of the cost as part of the capitation payment that is negotiated annually with the managed care organization.
- For Tribes, the federal government sets an “encounter rate” that is paid to Tribal providers of case management services. For each qualifying face-to-face service encounter (with one allowed per 24-hour period), the Tribe is paid the encounter rate. The payment is funded 100 percent by the federal government. The exception to this process is child welfare TCM, where the encounter rate is set by DHS based on an average of all child welfare TCM rates in the counties contiguous to the reservation. This payment is funded 100 percent by the Indian Health Service.

Waiver Case Management

Case management can also be a service that is provided in home and community-based services (HCBS) waiver programs under §1915(c) of the Social Security Act. In Minnesota, people enrolled in an HCBS waiver program are required to receive case management as one of the covered services. Case management services are available
under these waivers: Alternative Care, Community Alternative Care, Community Access for Disability Inclusion, Brain Injury, Developmental Disabilities, and Elderly Waiver.

Waiver case management has a set statewide rate set as part of the state budget process. Waiver case management is prior authorized as part of the community support plan and is billed in 15 minute units. Rates change only if approved by the legislature. The state pays the non-federal share for waiver case management and relocation case management. In a managed care model, a capitation is paid per member per month to provide necessary health services, including relocation case management, to eligible members. Service reimbursement is in 15 minute units.

Case management also is mandated for people with developmental disabilities or related conditions. Any person who meets the eligibility for this type of case management and requests it, must receive it. However, these case management services are only reimbursable through Medical Assistance if the person is eligible for the DD waiver or vulnerable adult/developmental disabilities TCM. For adults not eligible for Medical Assistance or for children not covered by a waiver or Medical Assistance, counties must provide case management with their county tax dollars.

Issues

- The time study methodology is controversial. It was designed to optimize federal revenue, but it can result in large variances in the monthly rates for similar services from county to county. For example, state fiscal year 2016 monthly rates for children’s mental health TCM ranged from a low of $327 per month in one county to a high of $2,453 per month in another county. This was also the case for county-contracted provider rates, ranging from $244 per month to $955 per month.

- Because the time study methodology is complex, some stakeholders feel that the process lacks transparency since it is difficult to understand or predict rates. DHS has made time studies non-transparent to try to prevent counties from manipulating their reporting to artificially raise their rates. The lack of transparency is a challenge for counties, who must manage the process, assure that they are doing an accurate job of completing the time study, train their staff in completion of the moment-in-time study, and create realistic budget forecasts.

- Tribal and county agencies’ spending of their own funds on case management is significant, so any changes to current processes could present significant risk to Tribes and counties. It might be necessary to revisit Tribal and county roles and responsibilities for funding case management services if changes are made to rate-setting methods.

- Any efforts to adjust or replace the time study methodology to make rates more consistent across MA-funded TCM services will likely result in winners and losers and possible loss of revenue to all or most Tribes and counties. Counties or providers who receive reimbursement on the high end of the range could see their rates reduced, and some on the low end of the range could see an increase in their rates. This makes it politically difficult to change to a new method. Rates adjustments might need to be done gradually so individual provider agencies and counties experiencing significant rate reductions don’t become financially unstable during the transition, and alternative funding sources might be required for activities that are no longer funded.

- CMS has communicated concerns about Minnesota’s bundled and cost-based processes for funding of case management services. Significant changes to case management services in Minnesota will require
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not only authorizing state legislation, but approval by CMS of revisions to Minnesota Medicaid State Plan Amendment (to respond to CMS concerns).

- Changing the rate setting methodology for child welfare TCM would require submitting a State Plan Amendment to CMS. Recent private consultation suggest that CMS may have concerns about how child welfare case management is funded throughout the U.S., and that there is a potential risk, including the possible loss of funding for child welfare TCM if a State Plan Amendment is opened.

- There are regional variations in case manager salaries and benefits, travel time necessary to meet with people receiving services, administrative costs, and local costs of living that impact the cost of providing case management services. Desire for a more standardized rate will need to be balanced with the desire to reflect real cost variations.

- CMS has its own opinions about the appropriate factors to consider in rate development, and these opinions are not always predictable or constant. If Minnesota were to change rate-setting methods, it would face a fair amount of uncertainty during the process.

Areas of agreement

- Any rate system for case management services should:
  - Allow flexibility and changes in the intensity or frequency of case management
  - Support organizations to hire qualified staff
  - Be a transparent rate methodology
  - Incorporate processes and produce rates that are more comparable across public and private case management providers

- Tribes and counties are heavily invested as a financial partner with the state in case management services. They should be actively involved in redesigning rate-setting processes.

- Any changes will take a great deal of financial analysis and implementation planning.

- Waiver case management rates changes must be approved by the legislature so case management redesign assumes that a legislative proposal will be prepared.

  - Case management redesign should be driven by the needs and strengths of people receiving the services and Minnesota’s vision for the service. Rate-setting methodologies can then be considered according to how they support that vision.

- At least for monthly case management rates, a tiered model of case management service rates should be studied further.

Past Recommendations

- DHS should review the current time study methodology for TCM services and modify as needed, or establish a new rates model to reduce the range of monthly TCM rates.

- DHS should study CMS communication about rates setting and describe options for complying with federal expectations and attaining more consistency of rates.

- DHS should revisit with Tribal and county partners the role of Tribes and counties in the financing of TCM services in which they currently provide the non-federal match.
• When a case management outcomes and measures reporting system is established and tested, study how a portion of TCM services reimbursement might be attached to performance measurement. This could be part of health care reform’s “paying for value” programs.

□ Tiering of case management services and reimbursement should be studied further as an option.

**Equity considerations**

• If case management provider agencies that serve under-represented communities are expected to do more outreach activities, should these providers’ rates be greater to reimburse for outreach efforts?

□ How should diverse communities be involved in the process of rate-setting redesign?

**V. A Proposed Roadmap for the Next Phase of Case Management Planning**

A clear message in the interviews conducted at the beginning of the information-gathering phase was that when DHS invites partners and stakeholders to engage in the next phase of case management planning, DHS should bring a summary of previous work and a clear proposal for moving forward. This should include a draft vision, goals, principles, services characteristics, and a project structure for planning. This section begins with draft vision, principles and goals for case management that are based on past work and the focus groups held in March 2016 and lays out a structure for re-convening partners and stakeholders in future planning.

**Proposed Case Management Planning Vision, Principles, Goals, and Service Characteristics**

DHS offers these vision, principles, goals and service characteristics as a starting point for collaborative development of a statement of vision, principles and goals for the next phase of case management planning.

**Vision**

The following vision statement reflects a summary of feedback received from stakeholders during the CM redesign information-gathering phase. DHS will continue to work with external partners and stakeholders to refine this statement:

**Vision for case management:** Services are simplified, flexible, person-centered, culturally responsive, and universally available to those who qualify for them. Services are flexible and variable in order to respond to the current needs of the people receiving services. Caseloads are manageable so case managers and the people receiving services can develop authentic working relationships to create and implement person-centered plans.

**Principles**

The next phase of case management redesign will be driven by the following principles. Some of these relate to the nature of the health and social services themselves; others relate to how we will proceed with the case management redesign as an organizational change.
Health and Social Services Principles

- **Person-centered, outcome-oriented care**: The service system should be responsive to the current strengths and needs of each person and family, with the intention of helping them to improve their health and wellness, live a self-directed life, and strive to meet the goals they set. We should focus on people’s outcomes—improvements in their lives—instead of on service outputs.

- **Public and private partnerships and collective responsibility**: A community-based service system requires collaboration and coordination among the governmental and non-governmental organizations and individuals (including those receiving services) who co-produce the service system.

- **Prevention and early intervention**: Resources are allocated to prevent problems or quickly identify them and keep them from escalating.

- **Empowered workforce**: The system must give case managers and direct service staff efficient tools and training in a positive work environment that encourages them to make and sustain authentic relationships with people receiving services and assist them in achieving their health and life goals.

- **Integrated Services**: Recognize the interdependencies between health, economics, social situation and individual circumstance and end the practice of program-based isolation of services.

- **Equity**: Design and deliver health and social services to eliminate service outcome inequities and population health disparities. The CM Redesign workgroup drafted a document that could help guide the equity work related to case management planning. This document is included in Appendix III.

- **Natural supports**: Public health and social services should reinforce and build on the strengths of community, friend, and family supports that surround each person.

Organizational Change Principles

- **Continuous and incremental improvement**: Combining shared big-picture vision and short cycles of planning, implementation, assessment and revision will bring success. Organizational “learning” requires outcome tracking, open discussion of failures, quick dissemination of successes, and long-term, high-level leadership’s commitment to redesign.

- **Experience-based design**: The redesign process should start from the experience of people and how they access and experience the system and the outcomes they attain. Planners can then work backwards toward changes in providers, services, management structures, or institutional relationships. Even CMS-driven changes like rate-setting redesign should be rooted in the experience of the people receiving services and their communities.

Goals of Case Management Planning

One reason that case management planning is so complicated is that it will have to achieve multiple—and sometimes conflicting—goals held by various partners and stakeholders in the process, including CMS, DHS, Tribes, counties, providers, payers and people who receive services. It also comprises multiple types of case management that have different goals and purposes. While we all honestly want to focus on the best outcomes for people who receive services, it’s not simple to translate their desires and circumstances into an integrated approach to case management. However, it appears that there are some goals that seem to cut across all of the
types of case management. These can help us focus our redesign efforts on the goals that matter most to people receiving services:

- Connecting people to services that they need to achieve their goals
- Supporting deep connections to friends, family members and communities that can support a person’s efforts to reach their goals over the long-term
- Ensuring both safety and the ability to take the risks one has chosen
- Ensuring permanency or stability
- Pursuing quality of life as defined by the person receiving services

### Desired Characteristics of Case Management Service Delivery (summary of feedback received)

This section lists the desired characteristics of case management that participants in past stakeholder input and the 2016 interviews and focus groups have identified. Feedback below is summarized into sections for people who receive case management services and their families, case managers, and funders and payers of services. Quotes in this section are paraphrases of comments made in the focus groups and interviews with people who receive case management services.

The most-often mentioned characteristic of the optimal case management system is not actually a characteristic of case management itself: it is the availability of adequate community-based services (to which people could be referred). People who receive case management services complained about the lack of specific services (especially in rural areas) or the long waiting lists for some services. Case managers said that if we had enough community-based services available in each locale, their jobs would be more do-able, more fulfilling and less stressful. Providers and payers of case management also recognized the need for a more robust community-based service system, and identified inadequate rates, workforce challenges and liability issues as key barriers to the development of more needed services.

“People are struggling because they have not established a provider. There’s no security net... there’s never been an abundance of resources. You can wait four months to get a psychiatry appointment. We’re pushing to use primary care with [persons with mental illness] and we shouldn’t be.”

### For People Who Receive Case Management Services and their Families and Guardians

People who receive case management services had many suggestions for improvement. It’s important to note that the focus group participants recognized the difficulties facing case managers and most felt that their case managers had done the very best they could to help them. The comments in this section mostly reflect difficulties in the system of case management and human services delivery, not failings of individual case managers.

1. **Effectiveness.** Perhaps most basically, people receiving services want a case manager and case management practices that connect them with the services that they believe will help them achieve their goals, whether those goals are to move into their own apartment, keep their family together, get a job, etc. They want competence and they want to be confident that the answers they get from case managers are accurate and complete.

“My care coordinator is the best. She is the one who told me how to get a bus card. That has been a huge load off me; I used to have to try to beg tokens off of services. That bus card is incredible.”
2. **Advocacy.** The service system is complex and there are many rules that determine eligibility, funding and service access. Case managers are put in the position of both providing access to services (from the perspective of the person receiving services) and being a gatekeeper to services (from the perspective of the payer organization). People receiving services want a case manager who will represent their needs to decision makers (for example, financial workers) and advocate for their interests.

3. **One person.** People who receive case management services are often frustrated by having to work with multiple people who are coordinating their services. One person can have multiple case managers because they receive multiple services, and some also have a care coordinator through their health care provider. In addition, they may have other contacts for various social services they receive. One participant in the focus groups reported that she has an annual planning meeting about once per month, each organized by one of the many people coordinating her services. Many people would like to have one person identified as their case manager, coordinator or advocate, and that person then coordinates across all of the services they receive.

“It’s not that I think only one person should work on my case, it’s just that I want to work with one person (the advocate). Then there can be other specialists behind the advocate who know the rules and the details. Don’t overwhelm me with a bunch of different workers. Or at least put them all in one agency, and then give us a contact within this agency.”

4. **Respect.** Assessors and case managers should show basic respect to the people they serve. This requires getting out from behind a computer and having human conversations, with eye contact and an interest in the person’s concerns. It also requires returning phone calls and emails in a reasonable time (even if it’s just to say that they don’t have an answer yet). Finally, it means recognizing that each person receiving services is unique and deserves support that is tailored to his or her strengths.

“What do I want from a case manager? Core competencies in your field, you respond to me in a timely manner (within a week), you know how to do paperwork and you do it right, you’re transparent about the services available for my son, and you treat my son and me respectfully. You don’t treat me like a beggar or a welfare cheat. I am a taxpayer; I am your boss. I’m not a cheater.”

5. **Helpfulness and reasonable expectations for people and their families.** People receiving case management want case managers who will give them the level of help that they need. Our interviewees told stories of case managers who handed them a list of providers and told them to “find one that meets your needs.” That is not adequate help for most people or family members who don’t know the service system and who are already struggling with the challenges that led to the need for case management in the first place. Several participants in our guardian or family and focus groups for people receiving case management were professionals who had deep experience with social services and the law, and they echoed a familiar comment: “If navigating this system is hard for us, with all the background experience we have, how could it possibly work for people who don’t know the system or have other barriers that we don’t face?”

“If [a person who receives services] does not have a loud, squeaky person advocating for them, they will get screwed. The case managers acknowledge this. Those who are effective advocates get the services.”
6. **Choice of case manager.** The relationship between the case manager and the person receiving services is fundamental to the success of services. Allowing choice among individual case managers within one providing organization was a primary concern for some people and family members; choice among provider organizations was mentioned less often.

7. **Continuity.** Once a good relationship between the case manager and the person receiving services has been established, disruption of that relationship hampers progress. One significant disruption occurs when teens transition to adulthood; both their relationships and the types of services they receive are disrupted, and many young people struggle during this period. At all ages, however, people receiving services also experience frequent disruptions due to turnover of case managers.

“I finally got a worker who doesn’t get scared and she knows how to work with me. I can trust her now. But I’m scared that she will pass me off like a football. I have been treated like a pinball—getting handed off from person to person. I wish I could case manage myself, but I can’t yet.”

8. **Integration.** People receiving services often have multiple health challenges and receive multiple services from multiple providers. Some have more than one case manager, and sometimes a family can have three or more case managers working with different family members. People receiving services often end up trying to integrate their care across the providers and systems they work with, which can be intensely frustrating. Better integration—for example, having hospitals notify county social services if a baby is born with severe disabilities, so that social workers can begin supporting the baby and family—would make the service system more effective and manageable.

“Sorting out my son’s VA services and his county services is confusing. It’s difficult to know who is responsible for what. It looks simple on paper, but it is not. I feel like I am the middle man. If I have question on financials, I ask the [contracted case management provider] and she’ll tell me to call the local county financial person. Then they refer me to X county, who has financial responsibility. Then they tell me to call the VA, and they send me back to the local county. So it’s a lot of navigation.”

9. **Adequate time and attention.** People who receive services are constantly frustrated by their case managers’ large caseloads, which prevent them from getting the attention and help they deserve. Some people suggested that there should be levels of case management, so that caseloads could be determined based on the level of need of the person receiving services.

“I recently transitioned to adult services, and my case manager has been very helpful. But she has a much larger caseload [than my former case manager], and she doesn’t have time for me. Now I have to compete for her time. Sometimes I’m just not up to it.”

10. **Some degree of control over the entire service process,** from assessment to oversight of service delivery. While different types of case management warrant differing levels of control, it makes sense to give people the maximum amount of control that they can successfully handle in order to ensure participation and positive outcomes. Person-centered planning, an approach used in many types of case management, promotes self-determination. However, some people receiving services report that the day-to-day delivery of services is not always person-centered. Side-by-side charting was mentioned by one person.
receiving case management services as a way to help assure that people understand and control the services they receive.

“Case managers should not start by saying, ‘here’s my plan for you.’ You can’t do that. Your client is the person who has a plan, and it’s the case manager’s job to help them implement that.”

11. **Manageability.** “Manageability” is the term one person receiving services used to describe the need for better communication and integration among service providers and case managers. Several interviewees described the challenge of coordinating among all their service providers and wished that they could receive all of their services in one place—where the various staff talked to each other regularly. They also wanted all of their providers to have access to their electronic records, so that they kept up with people’s status and each others’ services and recommendations. These practices would make the whole system more manageable for the people receiving services.

“It’s too much to manage all of those people to see. You end up case managing them. We need more manageability. When my case manager comes, I have to tell her what’s going on with the other [service providers]. Is that my job? I spend all of my time just catching her up on all the things I’ve been doing. And there’s no time to tell them what I need.”

12. **Adequate information.** One key to understanding the system is to have better materials that lay out how the case management and service provision systems work, and a list of what services are available. These should be easily accessible on a website that is kept up-to-date.

“When a kid turns 18-21, why is there not a list of all the things they might qualify for in their adult life? That should have a link to forms that explain each service and who to contact. I’ll bet even the case managers would like to have that list.”

13. **Flexibility.** Every person receiving services has a unique situation, needs and strengths, and these change over time. The more flexible the service system is, the more likely that solutions can be tailored to match that uniqueness. Case managers can provide some flexibility (for example, by flexing their work style to accommodate particular needs), but people also want more flexibility around the rules that govern eligibility and service provision. When everyone on a care team agrees about what should happen but there is a rule in the way, then there should be a way of bending that rule. And there should be an easy way to appeal decisions that are not person-centered.

“A lot of money could be saved with more flexible budgets... I have money in my son’s budget that I can’t use because it can’t go to transportation and that’s what he needs. So I use it to pay for things that aren’t so important... Flexibility will not create fraud; flexibility will create wiser spending.”

14. **Responsiveness.** People receiving case management emphasized the importance of responsiveness with comments like, “Even if they don’t have an answer yet, or if they can’t help me, it would be very helpful if they would respond quickly to my calls so that I know what’s going on.”

15. **Cultural sensitivity.** People receiving services want the option of choosing case managers who truly understand and respect their cultural background. This will require additional efforts to increase the number of case managers from diverse cultural backgrounds.
16. **Understanding of family system needs.** Families play a key role in service peoples’ ability to achieve their goals. Case management must acknowledge this central role and support the family system where possible. Several interviewees emphasized the opportunity of leveraging resources by supporting care givers so that they could help support the person receiving services. They also talked about the value of connecting family members with peer support networks; a few said that most of what they’d learned about negotiating the system had come from other families in similar situations, not from case managers.

17. **Compassion.** People receiving services and their families are often struggling with the day-to-day challenges of their lives and their disability, and case managers need an element of compassion and acknowledgement of that struggle in order to create trusting relationships with the people receiving services. Especially when a person or family are abruptly introduced to the service system, compassion is essential.

“When my son had his traumatic brain injury and was in a coma, the case manager who met with me (in the hospital) tried to do too much. You can’t take all their papers, apply for a waiver, and decide what to do with your son, all in a 2-hour period. They are not acknowledging the shock and trauma involved. They need to take time to hear the story, and then schedule another time to talk about very basic decisions. Then schedule future meetings for all of the complicated paperwork. You have to minimize the amount of thinking I have to do while I’m feeling like I’m being eaten from the inside out.”

18. **Accountability.** When people first begin receiving services, they (or their guardians and caregivers) should get training on their rights and reasonable expectations for the system, and what processes are available to address problems. In addition, focus group participants felt that someone outside the provider organization should check in with the people receiving case management services periodically to find out if they are happy with the case management they are receiving, or some kind of anonymous satisfaction survey should be conducted. They felt that complaints are rarely resolved in the current system; people are worried about complaining and alienating their case manager or the case manager’s supervisor. The Ombudsman’s office needs to be adequately funded and staffed to respond to complaints. Frequent complaints should trigger a review to see if a program’s certification or funding should be withdrawn.

19. **Consistency:** The availability of services and supports should be roughly the same no matter what county a person lives in or whom he or she receives services from. Almost all interviewees and focus group participants told stories of discrepancies in service availability, policies, and standards between counties or providers. Some reported feeling trapped in their current county because their services were working for them and they couldn’t risk moving to a different county where they might not get the same level of support.

“There are disparities in how services are delivered. Why is there leeway in one county and not in another? There should be flexibility, but there should also be core standards. Some counties are much more proactive and creative, and others are conservative.”

20. **Adequate funding:** All of the above characteristics have a financial dimension: it takes money to create useful, flexible services. Without adequate funding, problems are created that end up being costly in the long run. The low rates for some services, for example, create high turnover. This leads to constant
spending on training of new staff and creates disruption for the people receiving services. Considering the total cost of care of various services and new, relevant policies could help eliminate decisions that are a penny wise and pound foolish.

**For Case Managers**

1. **Lower caseloads**: The high caseloads that most case managers carry make it impossible for them to serve everyone adequately. New case managers, especially, have to have realistic caseloads or they just get overwhelmed and leave. Conditions existing in the lives of the people we serve dictate the level of case work intensity as well as the size of caseloads. Conditions existing in the lives of the people we serve dictate the level of case work intensity as well as the size of caseloads.

   “In X county, we recently reduced our adult caseloads from 70 to 50, and we’re down to about 40 on the child side. What’s really difficult is that even though we’ve reduced, with RMS and all these new demands, we’re paper-centered unless we’re working on a crisis… When someone has a difficult situation and I can see that I could jump in there and help, I can’t stick my toe in there because I can’t do that and handle the rest of my cases. So we rely heavily on providers, but they don’t have the same knowledge base we have. So the wheel goes around and around and around.”

2. **Less paperwork and more time with the people they serve**: Case managers recognize the importance of documentation and quality tracking, but report that they often spend more time on paperwork than they spend with the people on their caseloads. This is not person-centered. Time reporting was mentioned as one activity that case manager’s feel wastes time they could be better spending with people on their caseloads. The repetitive paperwork of re-assessments was another opportunity for streamlining. The Universal Transfer Form was mentioned as an example of an improvement in paperwork.

   “I spend more time on paperwork than I spend with the people I serve.”

3. **More prevention**. Case managers feel that some of the problems that people experience could be prevented if more services were available to them when their challenges first appear.

   “[A] respite/crisis [provider] didn’t return our phone calls and said they didn’t have enough information and couldn’t take [the child] until next week… that’s not a crisis [bed]… anyone that works with children knows respite is a very preventative service.”

4. **More social services**: Case managers told many stories of people they served whose health and welfare challenges stemmed from, or were exacerbated by, social determinants: lack of adequate income to purchase nutritious food, safe housing, transportation, education, etc. Some felt that the most basic “prevention” strategy would be an increased investment in anti-poverty initiatives that could help people gain access to the social determinants of health.

   “We need to start with supportive housing, food and shelter, then we move into increasing mental health and chemical dependency services and education services. We’re going to keep spinning our wheels if we can’t meet basic needs. I mean, we’re terminating parents’ rights because [the parents] have no place to live!”
5. **Better assessments.** Having the assessment process separate from the provision of services eliminates a potential conflict of interest, but some case managers feel that the cost of separating assessment from case management has been too high. According to them, training of assessors has not been adequate. Some assessors have not adopted person-centered thinking and they assume that people with disabilities are more vulnerable than they are. For people with mental health, the problem seems to go the other way: assessors don’t understand people’s mental health challenges and tend to under-estimate the need for services. By taking the assessment process away from the case managers who know the people best, they feel we have introduced a larger opportunity for mistakes than we had before. Plus, the case manager still ends up asking the person receiving services the same questions again, so the process is redundant. To them, the solution to the conflict-of-interest problem is worse than the problem was (if there was a problem).

“In our county, all the case managers in the DD unit are trained assessors... so when our assessment unit needs help, we’ll go out. And I have found that things are missed if you don’t have the case manager involved. That is scary...”

6. **Person-centered planning:** Case managers voiced strong support for person-centered planning principles and processes.

“Person-centered planning has helped us tremendously with making sure that people are as independent as possible. We are moving people to their own apartments left and right.”

7. **Adequate training:** Health and social services are complex and new case managers often struggle to help people whose needs are complex. Moreover, services are constantly in flux and case managers’ training rarely keeps up with those changes. This can get overwhelming and leads to burnout. Training needs to be provided in ways that fit with case managers’ ongoing work demands. Professional development and mentoring are also needed by many.

“I have seen them throw interns into situations that they can’t handle. It’s not fair to the person being served. That doesn’t work for anyone. Everyone deserves to have the best service, not someone who doesn’t know what they are doing.”

8. **Better support materials:** Case managers should have access to well-indexed materials that can help them quickly find answers to complicated questions. These would be useful to new CMs as they try to learn the complex rules, and would also be helpful for experienced CMs who are not very familiar with a new program or program change. They could even be written so that others could use them, too—guardians, family care-givers, people receiving services, etc. The state used to prepare such manuals but doesn’t do that anymore.

9. **Simplification:** Rules should be streamlined so that the system is not so overwhelming. There is just too much to learn. Especially for rural case managers, who are often responsible for a wide variety of services, it is difficult to know the details of all of the programs available.

“I’m in the developmental disabilities area, and the number of programs that we have to know and work with—ED waiver, CADI waiver, BI waiver, SILS, Family Support Grant, we do our own screenings, I have...”
two kids in placement so I have to do the out-of-home placement and the court stuff—and my case load is 80. I am changing jobs to be the childcare licenser in my county. Although I love the people I serve, I had to make this decision because I just feel stupid every day. The span of all those programs is too much.”

10. **Streamlining**: The rules and requirements for case managers have evolved in response to legitimate concerns, but they add up to a great deal of processing and paperwork that might not contribute to the goals of case management. Case managers would like to work with DHS to review these practices and design more efficient processes. For example, some felt that there should be one basic type of case management—no matter what the person’s specific health challenges are—and that one case manager should be able to provide all of the support and connect with specialists when needed.

“75 percent of the reassessment stuff is just a total waste of time... you create a [support plan] and give a copy to the family and its stuff they already know. How is that helpful to them?”

11. **Better technology**: Simplification could be aided by implementing better information technologies and software systems to eliminate duplicative work and improve access to information. This could also make it easier to coordinate with all of the professionals supporting a person, so that services could be more integrated.

“What makes sense is if MnCHOICES is connected to SSIS in some way, shape or form...we make referrals and complete the customized living workbook and send it out to DHS for approval. It comes back with simple errors [to be resolved] and you have to send it back and forth. By the time it’s all done, all the oversight is like spending a dollar to make a dime.”

12. **Stability**: DHS is implementing a steady stream of changes that are very challenging for case managers to learn and implement on top of all their ongoing work. It would be helpful if DHS could prioritize or make fewer changes at the same time.

“There’s just so many things rolling out... you spend so much time trying to figure [changes] out that by the time you do, there’s more changes.”

13. **Standardization**: While it may be difficult to make the same services available in every county, we should work toward that goal. Standardization of approach and of decision-making criteria should be possible to achieve now. It does not make sense that what county a person lives in affects what services they have access to.

“In my unit, we’re very clear that [the parent’s] intoxication level has to effect the safety of the child in order for us to stop a visit [between a parent and child]... however, there are other case managers, you walk in and look like you [were] high yesterday, have the old smell of alcohol on you from last week and [look like] you didn’t wash your shirt- and [they stop the visit]. That can be very confusing to the process ...”

14. **Information and idea sharing**: Case managers are so busy that it is difficult to share information and learn from each other, especially outside one’s own county. More effort should be made to give case managers opportunities to meet with their peers across their region or state. There could also be more sharing of
tools and forms; if one county has translated a form into a particular language, can that form be posted somewhere so that other counties can find it?

15. **Flexible provider standards:** While basic requirements for education and experience make sense to help assure quality, allowing for flexible provider standards is also necessary. There are many factors that make case managers successful with the wide variety of people they serve, and provider standards should be flexible enough to recognize alternative paths toward the skills needed to do the job.

16. **Expanded eligibility requirements:** People qualify to receive MA-reimbursed case management services according to their diagnoses and needs, and some case managers feel these requirements should be expanded. Having a diagnosis of post-traumatic stress disorder, for example, does not qualify one for case management services, but case managers feel that covering more trauma-related diagnoses could lead to better care and recovery. Others felt that an overall assessment of intensity of service needs should be the grounds for eligibility, rather than specific diagnoses.

17. **Culturally-sensitive services:** There should be more training and development of culturally-sensitive case managers and other service providers. Materials and forms should be available in the languages spoken by people across Minnesota, and interpreters should be easier to access. People should be asked about their cultural background and whether they would like to be assigned a culturally-specific case manager.

“I had a family that turned down $150,000 in funding because they didn’t know what they were signing.”

18. **Emerging roles:** As case managers struggle with the increasing demands of their caseloads, they see an increasing role for assistants who could take over some of their tasks, leaving them more time to concentrate on the work that truly demands all of their skills and experience. These lower-paid positions could leverage the expertise of case managers and be a cost-effective solution to meeting more needs of the people receiving services.

“If we had more support specialists to enter things in… to do more of the busy work, [it would help]… additional case aids [can address] transportation, visitations, and chasing down things with financial workers.”

19. **Reasonable rates:** The rates that are set for health and social services help determine how many people can get access to a service and whether that service can actually help them. Case managers felt that we should continually review our rates to make sure that they are well-matched to needs and that they cover the range of services provided. For example, reimbursement for child foster care only covers costs once the child is in the foster care home; it does not cover all of the work that goes into preparing the child, parents and foster family before the child arrives. Several said that reimbursement should reflect the intensity of service needs and the amount of time spent working with a particular person, rather than having one average rate for a wide variety of needs.

“In the consumer directed community supports (CDCS), in the Elderly Waiver, we have set budgets we cannot go over. Barely anybody can go into consumer directed community supports (CDCS) [under the Elderly Waiver] because there’s not enough money. We’d like to promote CDCS to save money but it’s just not realistic.”
20. **Local case management**: Some case managers spend hours driving to visit. For large rural counties, this driving is an everyday part of the job. Even urban case managers must sometimes drive long distances to visit the people for whom the county has financial responsibility but who no longer reside in that county. This time on the road takes away from time to meet with the people on case managers’ caseloads.

21. **Addresses for homeless people served by case management**: American Indian case managers described the difficulty of supporting people receiving case management who did not have permanent housing. They felt that case management should include establishing an address for homeless people, so that it would be easier to communicate with and support them.

22. **Better transitions**: Case managers identified gaps in programs such as when young people transition to adulthood and older adults qualify as “elderly.” The transition to the Elderly Waiver, for example, changes some of the services that a person qualifies for, leaving case managers scrambling to fill in gaps in services. They would like to see the services redesigned so that service eligibility doesn’t change due to an arbitrary change in the person’s status (such as turning 65). Referrals, transfers and closures should be based upon the person’s assessed need and goal achievement and not driven by unmanageable caseload sizes. A transition in community living or work should be intentional and planned with the person receiving services.

23. **Flexibility**: Program requirements are not always person-centered, for example, when people can’t retire because of the implications of retirement for their service eligibility. Case managers would like to see more flexibility so that they can design program benefits that are tailored to the unique circumstances and needs of each person.

24. **Designed with case manager input**: Too many times there are changes to the case management system that are problematic because planners (especially at the state level) did not consult sufficiently with the case managers who would be implementing the change. Sometimes the changes might work well for large urban counties, but not make much sense for smaller rural counties; other times it’s the other way around. Include case managers in any decision-making about the case management redesign.

“It would be good for the policy people making the changes to ask the people doing the work: Is this actually feasible? Get input from the people doing the direct work. If there’s a good plan, things won’t have to be constantly changed or modified.”

*For Funders and Payers of Services (local, state and federal governments)*

1. **Quality**: Case management services should meet standards of quality.

2. **Effectiveness**: Case management should effectively link referred individuals to the system of publicly funded and natural services and supports.

3. **Cost-effectiveness**: A central assumption of case management is that by connecting people with timely, effective services, we can help prevent exacerbations of symptoms and more acute needs in the future. Case management is an investment in good health outcomes.

4. **Oversight and accountability**: Case management services and outcomes must be documented well enough that payers can assess quality and cost effectiveness. Oversight must be maintained to ensure that rules are followed.
5. **Transparent and realistic rates**: Rates for case management should reflect the actual costs of the case management services provided.

6. **“Continuing stay” and discharge criteria**: There should be explicit criteria for determining when a person should no longer receive case management services.

7. **Intentional**: Case management services often remain open exclusively for people to access services and supports. For example, case management is kept open solely to ensure access to tenancy support and respite services. This should not be the only reason(s) for case management to remain open. Rather, people should have case management because they benefit from one or more core functions of the service.

8. **Streamline activities**: Paperwork timelines and expectations should be clear and consistent across the board. Assessments, plans and notes should be standard and help create efficiencies rather than overburden case managers.

9. **Realistic workloads and supervision**: Caseload sizes need to be based upon standard assessments, level of need, utilization and research on best practices.

10. **Training and consultation**: More training should be made available in an interactive environment to enhance discussion, information sharing and learning.

**For Case Management Provider Organizations**

1. **Adequate rates**: Rates for case management need to cover the costs—including the administrative costs—of providing the service at the expected level of quality. Rates must be adequate to ensure a robust pool of providers who can attract a qualified case manager workforce.

2. **Stable rates**: Providers need rate-setting mechanisms that produce stable or predictable rates from year to year, to allow for responsible business planning.

3. **Financial support for serving people ineligible for Medicaid**: Tribes and counties provide case management services for the people who need them, whether or not the people are eligible for Medicaid reimbursement. Providing case management for people who are not eligible for Medicaid puts pressure on their budgets and limits other services they can provide.

4. **Reasonable provider standards**: Education, experience, and training requirements for case managers must be reasonable. If standards are set too low, quality will suffer. But if standards are set too high, provider organizations will struggle to fill their vacant positions.
Appendix I: List of Interviewees

Don Allen, DHS-Budget Office
Lisa Antony-Thomas, DHS-Disability Services Division
Ann Berg, DHS-Federal Relations
Katherine Finlayson, DHS-Disability Services Division
Larry Goolsby, American Public Human Services Association
LaRone Greer, DHS-Children’s Mental Health
Jamie Halpern, Hennepin County
Tom Henderson, Brown County
Stacy Hennen, MACSSA and Grant County
Susan Krinkie, DHS-Child Safety and Permanency
Julie Marquardt, DHS-Health Care Administration
Deb Maruska, DHS-Special Needs Purchasing
Lori Miller, DHS-Disability Services Division
Meghan Mohs, Ramsey County
Chris Ricker, DHS-Financial Operations
John Sellen, DHS and Hennepin County
Richard Seurer, DHS-Adult Mental Health
Nan Stubenvoll, DHS-Disability Services Division
Brad Vold, MACSSA-Mower County
Jodi Wentland, Olmsted County
Bill Wyss, DHS-Children’s Mental Health
Cary Zahrbock, Medica
Marie Zimmerman, DHS-Health Care Administration
Appendix II: Case Management Redesign and Finances

This section of the document provides an overview of the funding structures for case management. It also provides historical context and an explanation of the various approaches to setting MA rates.

**AF Finances Should Support Program, not the Other Way Around**

1. **Finance as a Premature Constraint**

   In general when designing services, working out the finances should occur later rather than early in the process. It’s important to know what you want the financial framework to support first; otherwise, the financial framework starts dictating what it will support, the opposite of sound planning.

   Of course, resource constraints are important to face in any endeavor, and money represents many of those constraints. Finances can also be seen as more tangible and practical than other considerations. For these reasons and more, it is often tempting in designing a service such as case management to build the financial framework early on.

   However, experience suggests that planning finances too early in the design results in artificial constraints on service design. Consider this: Every financial model requires concrete choices of items such as acceptable providers, reimbursable activities, measures of activities, basis of cost, which costs are included or excluded, and units of service, documentation processes, payment processes, and so forth.

   Once determined, these can quickly become rigid constraints rather than useful reference points, forcing subsequent decisions that might otherwise go in more creative directions.

   For example, in order to set a cost-based rate for case management, one needs to decide which activities will be covered (assessment? equity? supervision? documentation? etc.), how those activities will be measured, and who to measure. Yet those actually should be design decisions based on how you want the service and the service delivery system to work, rather than something dictated by the rate-setting process.

   In some situations, the design chosen may not meet requirements for federal financial participation or may be too expensive. At such a point, there are often ways to work with federal requirements and still achieve the primary goals, or to bring costs down and keep key design elements intact. However, if one starts with the financial arrangements, those discussions never occur.

2. **History of TCM as an Example**

   It’s worth considering the history of TCM in Minnesota in this regard. The best public policy always pursues multiple goals (programmatic, finance, performance, quality, etc.), but the evolution of TCM has been dominated by optimizing federal reimbursement to county social service agencies (and later for Tribes), in order to finance other worthy policy objectives.

   Although never considered as a goal on its own, this focus on optimizing federal reimbursement has been termed for purposes of this discussion a “Comprehensive Federal Reimbursement” approach. It has involved examining all the services and activities performed by county social service agencies and then attempting to match those with services and activities that the federal government is willing to fund.

   As an example, the department proposed child welfare TCM to the 1993 Minnesota Legislature as part of a package of reforms to the child welfare system. The goal was to reduce Minnesota’s dependence on out-of-home placement as the primary tool in child protection and other child welfare cases. The overall package introduced
family preservation as an important public policy goal, with services provided to families to avoid removal of children or facilitate reunification after removal.

Child welfare TCM was included as part of this package. However, this was not in order to provide more case management – the consensus was that there was plenty of case management already being provided to families involved in child welfare cases. Instead, the development of child welfare TCM was explicitly a means to increase federal reimbursement, in this situation for case management activities in which Minnesota counties were already heavily engaged. By carefully defining these activities as TCM and filing appropriate state Medicaid plan amendments, this case management could then be included as federally reimbursable, using as match the in-kind costs that counties were already providing. The additional federal revenue was required to be used to expand preventive child welfare services.

At the time, counties were reluctant to use county funds as the non-federal match for child welfare TCM. They eventually agreed with the understanding that this was the only feasible way to gain the resources needed to build preventive child welfare services in Minnesota.

The department and other stakeholders followed the suggested order of determining policy goals first and finances second. However, it did not attend to thinking through what kind of case management should be provided, or by whom, or under what circumstances. At the time, those questions were deemed to have already been decided – what was already in place. Rate-setting and other requirements were determined primarily based on what would optimize federal reimbursement.

3. Financial Requirements for Change

The Minnesota Legislature has requested the department, in consultation with stakeholders, to study and make recommendations related to case management in Minnesota. In identifying areas to study, the legislature in effect suggests additional potential policy goals, such as statewide standards, consistency among different types of case management, transparency in rate-setting, and applicability of the same or similar rate-setting processes to public and private providers.

These are valuable potential goals. However, they will come at a cost.

Undoing processes designed primarily to optimize federal reimbursement to county social service agencies (and later Tribal social services), and replacing them with new processes focused on these other goals instead will almost certainly involve substantial losses of revenue to Tribes and counties, and likely other winners and losers as well.

In pursuing these goals the state of Minnesota needs to recognize that it will require considerable additional state funds in order to accomplish such potential reforms and make up for the consequent holes in funding for Tribal and county social service agencies, and perhaps for others.

B. Rate-Setting Approaches

This section does not discuss payment environments, such as payment for performance. Rate-setting assumes that a unit of service is already in play (see section D. Units of Service for more information).

There are many ways to address setting rates for a service. One useful way to classify them is to consider seven approaches:

1. Market-based
2. Negotiated
3. Cost-based
4. “Comprehensive Federal Reimbursement”
5. Capitation
6. Budget process
7. Informed budget process

In this discussion, the approaches are often simplified to better illustrate the concept behind the approach, rather than getting lost in the detail.

1. **Market-based**

Our society tends to value market-based rates, where the price or rate is set by the provider. In this approach, individual buyers decide whether or not to purchase from any individual provider based in part on the price or rate.

For goods or services that are readily available in a competitive market place, with few barriers to entry for providers and with good information available for potential consumers, the price of the good or service can be left to supply and demand. Greater supply will tend to push the market toward lower prices or rates and greater demand toward higher prices or rates.

When it works, most economists consider this to be an efficient price- or rate-setting process, because it tends to move supply and demand into rough equilibrium. Of course, it can also set supply below need, because demand is determined by ability to pay, not by need.

Fortunately or unfortunately, case management does not lend itself to this kind of market-determined rate-setting. In general, few of the requisite conditions apply: the services are not readily available, competition exists but is limited, there are often barriers for entry, and one of the reasons we need case managers is that there is insufficient information available for those who need services.

2. **Negotiated**

A negotiated rate is when a buyer of the service and a seller work together to agree on a rate. Ideally, both parties are reasonably well informed about the service and cost structure involved so that the agreed-upon rate works for both buyer and provider.

Although the market for case management may not be sufficiently developed to warrant market-based rates, negotiated rates are feasible. In fact, a negotiated rate-setting approach currently prevails for contracted TCM where counties provide the non-federal share. For contracted TCM (except for service relocation coordination, where the state provides the non-federal share), a lead county negotiates the rate for any providers based in that county. Other counties are expected to conform to the rates negotiated by the lead county.

This approach has been used only for contracted case management. A negotiated approach requires an independent buyer and seller. It is therefore not permitted by federal regulations for public entities such as counties where there is no independent buyer with a financial stake in keeping rates lower.

A negotiation process can result in rates that are meaningful to the extent that it is influenced by supply and demand. However, market distortions can render the resulting rate less meaningful.
The success of negotiated rate-setting also depends on the savvy and motivation of the negotiators. In some cases, the county does not have the time, information, expertise, or motivation to drive a hard bargain; in other cases, the provider is not well equipped to handle negotiations - to secure a sustainable rate.

The federal government has expressed reservations regarding Minnesota’s negotiated rate-setting process as it is currently used for TCM. However, the reservations do not appear to be about the approach so much as the specifics involved, such as exactly who does the negotiating, whether it represents a statewide and consistent process, and so on.

3. Cost-based

A cost-based rate-setting approach makes extensive use of data to determine how much the service costs to produce. Most frequently, this includes cost and other data from the recent past, but some approaches make use of budgeted or anticipated costs or other data as well.

A cost-based rate-setting approach is currently being used for TCM directly provided by counties, for TCM where counties provide the nonfederal share. For county-provided TCM (except for service relocation coordination, where the state provides the nonfederal share), rates are determined as part of the broader Social Service Time Study (SSTS) process.

For case management, a cost-based rate-setting approach typically involves segregating costs into three or more groups: costs that are allocated based on time, costs that are allocated directly or on some other basis than time (such as per square foot or per staffer), and costs that are excluded. For the costs that are allocated by time, a time study or log or other means is usually employed to determine how key staff spend their time, categorizing the time spent into percentages. Those percentages are often refined with other data, then multiplied by the costs that are tallied to be allocated using the time results.

Example 1

If the costs to be allocated by time are $100,000 and the only relevant percentage is 80 percent, then the time-allocated costs become $100,000 multiplied by 80 percent or $80,000. If another $10,000 is directly allocated, then the total cost of the service is $80,000 plus $10,000 to equal $90,000 per quarter.

At the end of these calculations, we know how much it costs for a period of time (typically month, quarter or year) to provide the service being measured. That cost is then divided by the best estimate of how many units of service have been or will be delivered during that period of time; the result is the estimated cost per unit of service.

Example 2

If the total cost of the service is $90,000 per quarter, and the number of units of service to be delivered is 900 per quarter, then the cost per unit of service is $90,000 divided by 900 which equals $100 per unit of service.

A cost-based approach has many advantages, but it can be labor intensive and requires training and consistent work by a large number of people. The federal government requires that a cost-based approach (or other approach that has a cost-based aspect to it) be used when a government entity (such as the state or a county) is providing a service. This is because the federal government wants to ensure that it is not paying a public sector entity more than the cost of the service. They are much less concerned about this for private entities, since the nonfederal share ensures that the state, county, or other government has a stake in keeping costs down. Nevertheless, there are cost-based requirements for private providers that we should attend to.
4. **“Comprehensive Federal Reimbursement”**

“Comprehensive federal reimbursement” is a term invented for this discussion. It is used here to describe the historical approach to determining federal reimbursement for counties in Minnesota.

Previously, “comprehensive federal reimbursement” has involved examining all the services and activities performed by county social service agencies and then attempting to match those with services and activities that the federal government is willing to fund. In the past there were other federal sources, but the primary ones remaining are Title IV-E and Medicaid (Title XIX).

Historically in Minnesota, this resulted in the development of the Social Service Time Study (SSTS) in 1985, and its subsequent slow and steady expansion to encompass Title IV-E and Medicaid administrative reimbursements. Next to develop was child welfare TCM rate-setting in 1993. Later developments were embracing adult mental health TCM, children’s mental health TCM, vulnerable adult/developmental disabilities TCM, and most recently, MnCHOICES assessments in 2013.

The development of child welfare TCM and later vulnerable adult/developmental disabilities TCM were explicitly means to increase federal reimbursement for activities in which Minnesota counties were already heavily engaged. There was no discussion of “wouldn’t it be good if this or that sort of case management were available.” Instead, these kinds of case management were already being provided. By carefully defining them as TCM and filing appropriate state Medicaid plan amendments, these types of case management were then included as federally reimbursable, using as match the in-kind costs that counties were already providing. The additional federal revenue was required to be used to expand services.

This is in contrast to adult mental health TCM and children’s mental health TCM, which were not being provided in any large quantity by counties or others until the services were established in the state Medicaid plan. However, once established, it became clear that redoing them to fit into the SSTS process would have many advantages.

For case management, the SSTS is a more comprehensive version of the cost-based rate-setting approach described above. For the costs to be allocated by time, the SSTS uses a random moment time study methodology. For each county staffer being sampled (primarily line social service staff), a handful of times each quarter are randomly selected. The staffer is asked to choose – from the available time study codes – which one most closely describes their activity at the time of the random moment. No individual staff person is sampled often enough to create a picture of what they are doing. However, the results are aggregated over many people, and together the results are statistically meaningful for the group overall.

To the extent that the SSTS is accurate and has been forged over the years in a comprehensive manner, this process tends to result in dividing county staff activities into categories that are federally reimbursable and those that are not federally reimbursable. Some percentages are used to reimburse counties directly for administrative activities. Others are used for setting rates for TCM where counties provide the nonfederal share.

The SSTS process has many detractors. Although technically elegant, it is not transparent. Counties have long requested additional feedback, finding it difficult to manage their operations without understanding a major input. But at least some within DHS see its lack of transparency as a virtue, convinced that lack of data is the only safeguard against counties “playing games.”

As currently functioning, the SSTS probably does a better job of characterizing the activities of large counties than of small counties, since small counties are grouped together to produce statistically significant results. Finally, the SSTS rate-setting process probably does a good job of determining which costs are federally reimbursable and which are not, but it may not always accurately determine which federal source is most appropriate. This can
result in rates that appear arbitrary and inconsistent when taken out of the over-all context. This is discussed further in the context of the month as a unit of service (see D3. “SSTS and Monthly Unit” for more information).

One of the challenges for case management redesign is to consider how to interact with this status quo “comprehensive federal reimbursement” package. Removing TCM rate-setting from this process would result in some advantages. Certainly, it otherwise would be difficult to achieve greater statewide consistency, to the extent that is of value. However, it could also leave counties without financial support for key local government functions. These unintended consequences are much broader than just case management, since it would also likely impact federal Title IV-E and Medicaid administrative reimbursements. As a result, an analysis of winners and losers, with the potential to fill behind for losers, must be much more comprehensive than simply tallying expected changes in case management reimbursement.

The discussion above has focused on counties, because that was the context in which this “Comprehensive Federal Reimbursement” approach evolved. It has to some extent been adapted for Tribes as they have become integral parts of human services in Minnesota. As the information-gathering phase continues, and the larger planning begins in 2017, DHS will partner with the Tribes to ensure there is understanding of the unique financial and service-related implications of any proposed changes to case management.

5. Capitation

Capitation (from Latin for head, as in per capita) sets overall rates for an array of services, typically on a per-member-per-month basis. Individual services included in the package are priced in part using data similar to the cost-based rate-setting approach. However, these costs are further refined using actuarial data and calculations to project the frequency in the overall population for whom the capitation is being set, resulting in a capitation increment for that service.

**Example**

Suppose the capitation is being calculated for 1000 members. If actuarial data projects that 5 percent of the population would use case management monthly, then the projected frequency of use would be 1000 multiplied by 5 percent which equals 50 per month. If the monthly cost is estimated to be $100 per month, then the projected monthly increase in costs would be 50 per month multiplied by $100 per month which equals $5000 per month. With 1000 members, the increment in the capitation to account for this service alone would be $5000 cost per 1000 members to equal $5 per member, per month.

Capitation rates typically are set for an entire basket of expected services. Because the administering entity has considerable flexibility in managing the money, there is often an expected savings written into the contract. For instance, the buyer might anticipate a 5 percent savings overall compared to simply totaling up the monthly costs of all the individual services. Under some circumstances, capitation rates include a negotiated component as well.

Minnesota uses a capitation approach for the managed care portions of some case management services, such as adult mental health TCM and children’s mental health TCM. Managed by the health plans, the capitation includes a small monthly increment to the per-member-per-month rate to account for the case management expected to be provided to the health plan’s members.

6. Budget Process

As used here, the budget process approach refers to the state budget process that results in the biennial budget enacted by the legislature. Rates remain the same as the previous year, unless specifically changed by the
Minnesota Legislature. The budget process may be influenced by many factors, but in the end, it is best characterized as a political process.

Successful proposals to increase or decrease rates may be the result of budget considerations (surplus, deficit, shifts from or to other budget items), overall inflation adjustments for a set of services or providers, constituency complaints, testimony in hearings, advocates and lobbyists, recommendations from DHS included in the governor’s budget (which are in turn influenced by many factors), and more. Currently, all MA Waiver case management rates and relocation service coordination TCM (for which the state provides the nonfederal share) are set by the state legislature using the budget process approach.

Example

Suppose key committee chairs are aware that service providers are having a hard time keeping qualified staff, and rates that haven’t increased recently have been cited as a primary cause. Hearings have been filled with people testifying to the importance of a rate increase. The governor did not include an increase in the DHS budget request, but influential legislators are determined to do something. The requested 5 percent increase is projected to cost $1,000,000. Struggling with its budget targets, the legislative conference committee agrees to spend $400,000, or 40 percent of the requested amount. Because 40 percent multiplied by 5 percent equals 2 percent, the conference committee proposes a 2 percent rate increase which costs $400,000. Lobbyists agree to go along, hoping to do better in two years. The governor signs the bill, and a 2 percent increase goes into effect on July 1.

7. Informed Budget Process

An informed budget process refers to additional formal elements that include cost-based data. Although the final decision remains with the legislature, and is fundamentally political, this can have an impact on the context and the discussion. No Minnesota case management rate uses an informed budget process, as described here. However, a good example is the Minnesota nursing home rate-setting process. DHS staff members are assigned this as part of their ongoing responsibility. They do careful analysis of nursing home costs, which is submitted to the legislature. This analysis creates part of the context within which the legislature makes decisions on nursing home rates.

C. Who Pays the Nonfederal Share?

In the 1960s-1980s, Medical Assistance (Minnesota’s version of Medicaid) routinely split the non-federal costs for all services between the state and the county of financial responsibility. However, on January 1, 1991, the state assumed the non-federal share for all MA services (cash flow transactions on the state takeover continued into 1995).

Subsequent to 1991, a few exceptions have occurred in which counties, rather than the state, pay all or part of the non-federal share, and several of those exceptions involve TCM. At this point, counties pay the non-federal share for TCM (except for relocation service coordination, where the state pays the non-federal share).

When child welfare TCM was created, counties already were paying for the case management involved. Counties were very concerned during the 1993 legislative session at which DHS proposed that the in-kind costs already incurred by counties be used as the non-federal share of child welfare TCM. These concerns were about undoing the principle finally established just a few years earlier that the state would always pay the MA non-federal share. However, in the end, counties acceded to the proposal, concluding that the additional federal funding for preventive child welfare services – funding that could grow over the years – was worth their paying the non-federal share. Similar reasoning later added adult mental health TCM, children’s mental health TCM, and
vulnerable adult/developmental disabilities TCM to the short list of services where counties pick up the non-
federal share.

This historical bargain (counties agreeing to pay the nonfederal share in order to gain access to needed resources) would need to be re-evaluated in any case management redesign. As part of a comprehensive financial analysis, the likely shift in focus away from optimizing federal reimbursement toward emphasizing other policy goals would make who should pay the nonfederal share part of the discussion.

There is another major county cost beyond the non-federal share of MA. Counties must pay the entire cost of case management provided to any individual who is not covered by a public health care program, or who is under-insured through private insurance.

**D. Units of Service**

Deciding on what to use as the unit of service is an important decision in case management financing. At present, MA waiver case management and relocation service coordination (all of which the state pays the non-federal share) have 15 minute (quarter hour) units of service. In contrast, all types of TCM except for relocation service coordination (for which counties pay the non-federal share) use the calendar month as the unit of service. These two contrasting units of service play out in different ways.

1. **Quarter Hour as Unit of Service**

When the quarter hour (15 minutes) is used as the unit of service, each provider must maintain detailed time records of how case managers spend their time and on whose behalf. These time records are used for billing purposes. When a case manager spends more time working on case management for a particular person, more quarter-hour units get billed. When a case manager spends less time, fewer units get billed. This straightforward relationship appeals to many.

It is not a coincidence that the same types of case management that employ the quarter hour also use either the budget process or capitation as the rate-setting approach, and that these are also the same types where the state pays the non-federal share.

2. **Month as Unit of Service**

It is also not a coincidence that the same types of case management that employ the month use the SSTS for rate-setting as part of a comprehensive federal reimbursement approach, and that these are also the same types where the county pays the non-federal share.

Rather than billing for each quarter-hour unit, the monthly unit of service relies on a “trigger event”. These events vary slightly by type of case management, but typically involve a contact between the case manager and the person being served. This trigger event is deemed sufficient evidence that the case manager is providing a full month’s worth of case management, and is the basis for billing.

The monthly unit of service represents an average cost. Some people being served will receive more and some less, but on average will receive case management valued at about what the rate represents. (Although the variance is less, the cost of a quarter hour of case management would also vary.)

3. **SSTS and Monthly Unit**

Without a rate-setting process such as the SSTS, the month would not be feasible as a unit of service. When it works properly, the SSTS rate-setting process does more work on the front-end (rate-setting) and reduces the
work on the back-end (billing). A county that provides extensive case management, keeps a lower caseload size, and has higher costs (employees, space, computers, supervision, and other overhead) will tend to get a higher rate. A county that provides less extensive case management, keeps a higher caseload size, and has lower costs will tend to get a lower rate. If things change, these should be reflected in changed rates the following year, when the process works properly.

Suppose that a county tried to minimize the length of time that their case managers spent with any one person, and focused on accumulating as many trigger event contacts as possible. Although this would be successful as a way to earn additional revenue during the first year, the next time rates were calculated, the rates for this county would plummet.

Of course, as discussed above, the SSTS rate-setting process does not always work properly. In particular, the SSTS rate-setting process is never transparent and does not always yield results that are easily understandable, especially removed from the comprehensive federal reimbursement process. It probably does a better job for large counties than for small.

And without effective feedback, counties are unable to pinpoint serious problems with the SSTS in areas such as training or use of codes. This can result in serious distortions that cause rates to be unrealistically high or low.

For example, one county had previously used data from SSTS random moments to isolate distortions with its children’s mental health TCM rate. What it discovered was that child welfare workers, providing case management to particularly challenging child protection cases with children’s mental health aspects, felt that their work met the criteria for children’s mental health TCM. Accordingly, they frequently selected the children’s mental health TCM codes on the SSTS instead of the more appropriate child welfare TCM, even though they were not receiving the required clinical supervision nor following the other requirements of children’s mental health TCM. When staff were retrained, the child welfare TCM rate increased and the children’s mental health TCM rate decreased. However, that county no longer has access to the data it used to do that analysis.

More recent DHS processes have eliminated that kind of feedback, so any similar problems are going unnoticed, although they presumably are contributing to the implausible rates calculated through the SSTS rate-setting process.

4. Private Providers Use Months; Tribes Use Encounter Rates

Originally designed for county-provided case management, the month has been extended as the unit of service for contracted case management providers. These may be less well-suited applications, at least without the same kind of systematic rate-setting processes in place for those uses.

When adapted for Tribal social service agencies, a different approach was taken. Instead of using months as the unit, an encounter rate was developed. The encounter rate (the amount paid for each encounter with the person) was based on an analysis of the monthly rate received by relevant neighboring counties, which in turn were established through the SSTS process. This may be a simple way to estimate costs, but it eliminates the feedback loop built into the SSTS for counties. As a result, if a county lowered its caseload, it would tend to increase the monthly rate for the county the next time rates were set. On the other hand, if a Tribe lowered its caseload, the encounter rate will still be based on neighboring counties and remain unchanged.

5. Federal Concerns

The federal government has expressed reservations about Minnesota’s use of the month as its unit of service for case management. Rather than seeing it as an average of a month’s worth of case management, CMS wonders if
this represents a bundled rate, encompassing more than one kind of service without properly breaking it down. Minnesota will need to respond to these concerns.

Appendix III: Equity Considerations in Case Management Planning

DHS recently adopted a policy on equity that directs staff to incorporate equity analysis into the development of all policies and to authentically engage persons from cultural and ethnic communities before policy decisions are made. This includes Tribes. Tribes need to be engaged from the beginning on a sovereign nation to government level. The Case Management Redesign project is in an information-gathering phase, and thus is not yet considering particular policy options or decisions. What is the appropriate analysis to be undertaken at this stage of a project?

To answer this question, the Case Management Redesign workgroup invited co-workgroup member LaRone Greer, and member of the Community Supports Administration’s Equity Committee, to talk with the group about how to proceed. LaRone’s presentation and the ensuing team discussion identified six major efforts to be made at this stage of the project and throughout the life of the project:

1. **Definition of equity**: Adopt a definition of equity that can be used for the duration of the project.
2. **Conceptual model**: Develop a conceptual model for the project that takes into account the contextual factors that produce circumstances that lead people to need case management services and that constrain their efforts to reach their goals.
3. **Access and empowerment**: Consider access to decision-making as an empowerment tool, and create a stakeholder participation plan that identifies subpopulations to be included in the planning process and methods for assuring their authentic participation.
4. **Demographic data**: Gather demographic information to better understand the subpopulations that are currently receiving case management services.
5. **Issue review**: Consider each of the eight legislative directions for the CM redesign work and identify any particular equity-related issues implicit in each direction.
6. **Equity analysis tools**: Gather and review equity analysis tools that could be used in the CM redesign work once we begin to analyze particular policy options.

This document responds to each of these six points.

A. Definition of Equity

The DHS equity policy defines equity as “the state or quality of being just and fair towards all people in the delivery of health care and human services.” Equity does not mean that everyone should receive the same level or type of services because people face quite different circumstances that enable or constrain their opportunities and lead to widely varying strengths and weaknesses. Health and social services are like the boxes in Figure 1; they help people receiving the services to attain health and wellness (the apple). This highlights the importance of focusing on the outcomes of services, not just on the amount of services provided, or service outputs. When outcomes don’t meet the established goals, it’s a chance to look for unwitting biases or barriers that may be leading to ineffective or unresponsive services.
The CM redesign workgroup also considered the importance of engagement in thinking about equity. As one person framed it, “What if the people aren’t even reaching for the apples?” The group acknowledged that health and human services—except for some mandated services like child welfare TCM—are services that people can choose to accept or not. Everyone has the choice about how they want to live: how many of us decline to exercise, even though we know it would be good for us? Once a good faith effort has been made to design and deliver truly responsive services, if a person declines to use them, then the focus should shift to relationship-building in order to create more engagement (for example, through peer specialists or culturally-competent community health workers). If that also fails, and a person has poor outcomes, the group agreed that that should not be considered a failure of equity. To assume that everyone has the same ultimate goals is presumptuous; everyone gets to choose their goals and what services they do or don’t use. However, failures of this type should always warrant ongoing conversations to help reveal hidden biases or new opportunities for engagement.

While DHS’s equity policy focuses on inequities experienced by communities of color, American Indians, and the disability community, the CM redesign workgroup felt that equity in case management would require a wider focus that could include immigration status, gender and sexual orientation, income level, and other factors. If our vision is that Minnesota is a place where all people are valued contributors to their communities and receive the support they need to reach their full potential, then almost any kind of systematic disadvantage has the potential to limit attainment of that vision.

LaRone pointed out that promoting equity is always a balancing act. Most decisions involve competing goals and constraints on resources. It does not make sense, for example, to institute a policy requiring culturally-specific case management services in every county in Minnesota because that would require more resources than some counties have available. Also, we need to create trainings and consultation to support our providers as well. So developing culturally-specific programs in areas with larger populations of a particular cultural group might make sense, and promoting cultural sensitivity (through hiring diverse staff and investing in staff development) might be a more realistic goal in rural areas with predominantly white populations.

**B. Conceptual Framework for Considering Equity**

The following conceptual framework is built on an understanding of the social determinants of health and how those determinants affect health outcomes. In explaining the social determinants of health, the World Health
Organization’s Commission on the Social Determinants of Health identified three conceptual relationships that help determine health and health inequities:\(^5\)

1. The social, economic and political context into which someone is born plays an important role in that person’s socioeconomic position.

2. A person’s socioeconomic position (as evidenced by class background, gender identity, race, ethnicity, etc.) shapes the social determinants of health: a person’s living and working environment, their access to food, transportation, health care, their personal behaviors, their biological predisposition to health and disease, psychosocial perspectives, etc.

3. These social determinants of health, mediated by the health care system, affect the health of individuals and the unequal health outcomes of populations.

*Figure 2: World Health Organization Commission on the Social Determinants of Health’s Conceptual Framework*

One benefit of this conceptual model is that it provides a very general map of extremely complex interactions among factors that produce health outcomes. In the planning phase of a project, it is useful because it allows us to think broadly about how a new project affects the totality of the systems that ultimately produce health. It emphasizes that MA funded case management exists mostly within the “health care system” arrow. The model draws attention to the larger social and economic forces that affect health and health inequities and helps contextualize our investments in health care. The improved access to health care (and related social services) that case management redesign might bring will probably not be enough to counter the effects of the social

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determinants of health. Understanding this fact helps us stay realistic about what the possible impacts of our efforts can be.

C. Access and Empowerment for the People We Serve

According to the World Health Organization report, “any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups.” Could such a redistribution be assisted by the redesign of case management services? There are several dimensions of “empowerment” that have the potential to redistribute power and thus have an impact on health disparities, and they all involve communication and access to the decision-making processes. The project plan could include these activities:

- Create conversations that explicitly raise the structural, unequal distribution of key social and material goods as a source of health disparities.
- Establish policy decision-making processes that include the people likely to be affected by the decisions.
- Make an explicit commitment to reducing disparities as one important goal to be achieved in this project.

Ultimately, the point of access and empowerment is not to design a service system for disadvantaged populations, but to allow disadvantaged people to exert control over the processes and services that affect their wellbeing.

In the information-gathering phase of the project, DHS staff interviewed Rev. Green and Kim Lutes, the CM redesign workgroup’s two representatives of people receiving case management services, to talk about how to ensure that people who receive case management services have their voices heard. Here are the recommendations they made:

- **Voices of people we serve**: The project plan that is produced to guide the case management redesign project should include a section on how people who receive case management services will be involved in the project.
- **Professional advocates**: One form of participation is to involve professional advocates for people receiving services, perhaps by sitting on a steering committee. But professional advocates are not the same as actual people we serve; we need both.
- **Panel of people we serve**: DHS should partner with some advocacy organizations to help us create a panel of people and families who receive case management services that would meet occasionally to inform and provide feedback on the work. It may be necessary to create more than one panel if people’s concerns are too different across the many types of case management being considered.
- **Inclusion of diverse voices**: Make sure that any panels of people being served represent ethnic, cultural and racial diversity, or if that is not practical, set up additional groups that represent ethnic, cultural and racial diversity.
- **Pay for expenses**: Include money in the project budget to pay a stipend and travel expenses for participants who are not paid by some other source for their participation.
- **Input from related projects**: Consider the possibility of tapping into other DHS projects’ panels of people receiving services (e.g., the Domestic Violence and Maltreatment workgroup) to get input on case management redesign.
• **Participant preparation:** Make sure that people receiving services are prepared to participate in panels, including providing them with background information, lists of acronyms and briefings before meetings.

• **Respect:** Set group discussion norms to minimize acronyms and encourage respectful participation by everyone. Don’t fall into the trap of inviting people we serve to meetings and then ignoring them during the conversations. Make a point of getting their input occasionally. Loosen up the communication norms so that people feel free to stand up and move around if they need to.

• **Scope of project:** Be honest with all participants about the scope of change that is possible or likely. Do not ask for feedback on issues or features that are unlikely to change.

• **Authentic participation:** Be clear about what kinds of input you want from participants. The people we serve are experts on the types of assistance they want, how they want that assistance to be delivered, how they want to interact with their case manager, what types of services they want, etc. Then it’s up to paid policy experts to figure out a policy system that would make those things possible. It doesn’t make sense to ask the people we serve about technical aspects of rate models, and it doesn’t make sense to have policy experts deciding what people receiving services should want. Together these perspectives could help design a system that works.

**D. Demographic Data**

One of the problems in past case management redesign projects has been the lack of systematic data about case management utilization in general, in addition to more specific data on utilization and impacts on various subpopulations. The quality of available data varies from county to county, and the possibilities of statewide analysis using available databases have not yet been well explored. Any future planning must include objectives that address the need for consistent and ongoing data gathering and analysis.

**E. Issue Review**

Each of the issue areas defined by the legislature is likely to raise opportunities and issues for disadvantaged groups. Promoting choice of provider of case management, for example, could help minority populations to find culturally sensitive or culturally specific case management services. This could lead to more appropriate service referrals and more successful outcomes. The CM redesign workgroup decided that any summary of past legislative reports should include a subsection on equity for each of the eight policy categories. While this will not contain a detailed equity analysis like the ones prescribed in the equity review tools, it could help identify places where an equity analysis will be needed and alert planners and stakeholders to the need for an equity “lens” on that topic. Also, civic engagement needs to be a strong component of this work through the entire planning and implementation process. DHS needs to devote adequate resources to facilitate meaningful engagement with the community including the use of “culturally adaptable practices such as providing for language access, developing new channels to cultivate relationships, using facilitators from cultural communities, using culturally tailored materials and methods and developing materials that use plain language. It also calls for compensating or reimbursing community organizations and individuals who participate in planning, implementing and evaluating state agency work. Case management redesign is positioned to deliver on these strategies through the planned evaluation activities and by providing several platforms for engaged dialogue between stakeholders and people we serve.
F. Equity Review Tool for the Information Gathering Phase of Projects

DHS’s Community Relations division recommends the [King County Equity Impact Review Tool](#) as a mechanism for implementing the DHS equity policy requirement that equity be considered in all policy decisions. The Government Alliance on Race and Equity’s “[Racial Equity Toolkit](#)” is also recommended, as is adopting the goals and strategies identified in [the civic engagement plan](#) developed by the Governor-created Civic Engagement Committee. These tools will be reviewed and integrated into all future planning work.