

# **Case management reform for persons with disabilities in Minnesota**

**Disability Services Division**

February 2011



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Minnesota Department of **Human Services**

## **Legislative Report**

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## **EXECUTIVE SUMMARY**

The 2010 Legislature required the Minnesota Department of Human Services (Department) to develop recommendations and propose legislation to make changes in case management for persons with disabilities in Minnesota.

Case management is a service defined by the Centers for Medicare and Medicaid Services (CMS) and authorized under §1915(g) of the Social Security Act. As such, Minnesota receives federal Medicaid dollars for case management. The rate of federal financial participation for Minnesota is 50% federal dollars and 50% non-federal dollars.

The challenges facing Minnesota's case management system have been previously examined in several reports from DHS to the legislature that also included recommendations for reforming case management. There have been three reports in this decade alone; the most recent is the 2007 report, "Redesigning Case Management Services for People with Disabilities in Minnesota." Recurring challenges identified in each of these reports include:

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

It is important to note that the Department began several long-term care reform initiatives that were funded during the 2009 legislature. Combined, these initiatives will fundamentally change Minnesota's long-term care system. Accordingly, they will establish the new environment for the case management system as recommended in this report. The reform initiatives include:

- MnCHOICES – The MnCHOICES initiative will establish a uniform, comprehensive assessment process for determining eligibility for long-term care services, including home- and community-based services, and redefine the components of case management as service and administrative functions.
- Provider Enrollment and Provider Standards Initiative (PEPSI) – PEPSI will create a consistent statewide mechanism for enrolling providers and enhancing provider standards that will bring the state into compliance with federal and state requirements, streamline administrative activities for lead agencies and providers, create a provider verification system for lead agencies to identify enrolled providers, develop and evaluate strategies to monitor the performance of providers in the form of a provider framework and develop a DHS agreement with lead agencies based on newly defined roles.

- Rate-Setting Methodology Initiative (RSMI) – RSMI will create statewide rate setting methodologies for waiver services that will bring DHS into federal compliance, identify components of each waiver service, determine standard values for each service component and establish methodologies to create rates based on service components and individual needs.

The 2010 case management legislation outlined the following three areas to consider: (1) define, and improve funding for, administrative and service functions of case management; (2) standardize and simplify case management processes, standards, and timelines; and (3) increase consumer choice of case management. The legislation also instructed the Department to give consideration to the recommendations from the 2007 report, “Redesigning Case Management Services for People with Disabilities in Minnesota.”

This report provides a summary of the analysis and the recommendations made. These include next steps/implementation recommendations, if any, and associated costs, where applicable, for each of the following recommendations:

- **Separate the functions of and payment for the administration and service of case management; change the name of the service of case management to service coordination.**
- **Keep case management as a waiver service and develop a targeted case management service for persons with developmental disabilities who are not on a waiver.**
- **Build on current strategies to improve the efficiency in the administration and provision of case management.**
- **Eliminate Personal Care Assistance from the definition of Excluded Time in Mn. Stat., Chap. 256G.02, subd. 6. Examine the Unitary Residence Act especially as it relates to long-term care services and conduct a study to determine the effect of changes in County of Financial Responsibility and County of Residence.**
- **Change Host County Concurrence to Host County Notification.**
- **Increase opportunities for consumer choice of case management service coordination; develop provider qualifications and a rate for the service of case management service coordination.**

While the 2007 case management report identified costs of recommended changes in their report, the data was from 2005. The Department will need to redo the cost analysis of these recommended changes.

Finally, the Department recommends continuing the Case Management Reform Work Group (Work Group) in 2011 to address implementation barriers, analyze data, etc., and expanding the Work Group to include other areas of the Department, i.e., Mental Health, Aging and Adult Service, Children and Family Services. This will allow the Department to more broadly implement the vision of this report while tackling barriers.

## I. PURPOSE OF REPORT

The 2010 Legislature required the Minnesota Department of Human Services to develop recommendations and propose legislation to make changes in case management for persons with disabilities in Minnesota. Specifically, the Laws of Minnesota 2010, Chapter 352, Article 1, Section 27, state:

### CASE MANAGEMENT REFORM

- (a) By February 1, 2011, the commissioner of human services shall provide specific recommendations and language for proposed legislation to:
- (1) Define the administrative and the service functions of case management for persons with disabilities and make changes to improve the funding for administrative functions;
  - (2) Standardize and simplify processes, standards, and timelines for case management within the Department of Human Services, Disability Services Division, including eligibility determinations, resource allocation, management of dollars, provision for assignment of one case manager at a time per person, waiting lists, quality assurance, host county concurrence requirements, county of financial responsibility provisions, and waiver compliance; and
  - (3) Increase opportunities for consumer choice of case management functions involving service coordination.
- (b) In developing these recommendations, the commissioner shall consider the recommendations of the March 2007 Redesigning Case Management Services for People with Disabilities in Minnesota report and consult with existing stakeholder groups, which include representatives of counties, disability and senior advocacy groups, service providers, and representatives of agencies which provide contracted case management.

In response, DHS formed the Case Management Reform Work Group in September, 2010, and invited key stakeholders to participate. (A list of the Work Group members' names and organizations or groups can be found in Appendix A.) The Work Group served in an advisory capacity to the Department and met every two weeks over a four month period from October 2010 through January 2011.

This report outlines the discussions and includes a summary of the Department's recommendations for changes to the case management system for people with disabilities in Minnesota.

## II. BACKGROUND

In long-term care, case management is commonly understood as an activity that assists eligible individuals in accessing needed medical, social, educational and other needed services. Thus, “case management is not the direct provision of care and services, but instead is a separate and reimbursable class of services under Medicaid that for specific beneficiaries, identifies necessary services, assists in locating the services, identifies providers and monitors the provision of care.”<sup>1</sup>

Case management is a service defined by the Centers for Medicare and Medicaid Services (CMS) and authorized under §1915(g) of the Social Security Act. As such, Minnesota receives federal Medicaid dollars for case management. The rate of federal financial participation for Minnesota is 50% federal dollars and 50% non-federal dollars. Federal policy provides two basic methods to secure Medicaid dollars for case management: service claiming and administrative claiming.

Service Claiming: The service of case management can be funded in different ways. For example, under §1915(g) of the Social Security Act, states may target a subset of Medicaid beneficiaries to receive case management services as a State plan benefit. This form of case management, known as “targeted case management,” is a Medicaid state plan service and an entitlement to persons who are eligible and receiving Medical Assistance. Minnesota has several targeted case management groups:

- Vulnerable Adults and Adults with Developmental Disabilities (VADD)
- Child Welfare Targeted Case Management (CWTCM)
- Mental Health Targeted Case Management for Children or Adults (MHTCM)
- Relocation Service Coordination (RSC)

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, persons enrolled in an HCBS waiver program are required to receive case management as one of the covered services. Minnesota’s five HCBS waivers include:

- Community Alternatives for Disabled Individuals (CADI)
- Traumatic Brain Injury (TBI)
- Community Alternative Care (CAC)
- Developmental Disability (DD)
- Elderly Waiver (EW)

Only persons who receive services through one of these waiver programs have access to case management as an HCBS waiver service. However, some of these people may be eligible for targeted case management as well. And, although some people have access

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<sup>1</sup> Sara Rosenbaum, *The CMS Medicaid Targeted Case Management Rule: Implications for Special Needs Service Providers and Programs (CHCS 2008)* available at: [http://www.chcs.org/usr\\_doc/CMS\\_Medicaid\\_Targeted\\_Case\\_Management\\_Rule.pdf](http://www.chcs.org/usr_doc/CMS_Medicaid_Targeted_Case_Management_Rule.pdf).

to one or more types of case management services, others do not have access to any case management services. For example, a person who has a physical disability and is not on an HCBS waiver typically does not have access to any case management service under Medical Assistance in Minnesota.

Administrative Claiming: The second method of securing federal Medicaid dollars for case management is administrative claiming. Federal regulations allow states to receive administrative cost recovery. These are costs that a state incurs to operate its Medicaid program. Many case management activities can be claimed as an administrative expense such as service and program eligibility determination, level of care authorization, quality monitoring and other “gatekeeping” functions.

States have discretion regarding how they operate their Medicaid programs as long as they follow federal guidelines. Minnesota is one of 12 states that have a state-regulated, county-administered governance structure. In other words, the state has delegated certain functions to the counties to assist in the administration of the Medicaid program. The payment mechanism to counties for some of these delegated functions is case management.

For the most part, both the service of case management and the administrative functions of case management are the responsibility of counties. However, the state holds contracts with Tribal Governments to administer some programs similarly to the counties. Additionally, Minnesota has a very robust managed care system; the state holds contracts with health plans to administer certain programs as well. These contracts were designed around how the current system is structured. All of this adds to the complexity of the case management system and makes changing the system that much more difficult.

In addition, how case management is billed and claimed varies by funding stream as well as by who provides the matching funds to secure Medicaid dollars. For example, the state provides the matching funds for the service of case management in the HCBS waivers, and it is billed in 15-minute increments. In contrast, for VA/DD targeted case management, the counties provide the matching funds and the billing method is a monthly rate.

Currently, counties and tribes are reimbursed for administrative functions through one of several time studies (e.g., the Social Services Time Study or, for the tribes, the Medical Assistance Tribal Time Study). These are random moment time studies that are statistically validated and approved by the federal government in order to draw down the federal financial participation. All counties are required to participate in one of these time studies in order to get reimbursed for administrative functions.

According to the 2007 Report, “Redesigning Case Management Services for People with Disabilities in Minnesota,” “Minnesota has been very effective in securing federal Medicaid dollars to fund case management. However, the price that is paid for securing these funds is an administrative burden at the county and case manager levels.” (The executive summary from the 2007 Case Management Report is included in this report as Appendix B.)

The challenges facing Minnesota's case management system have been previously examined in several reports from DHS to the legislature that also included recommendations for reforming case management. There have been three reports in this decade alone; the most recent is the 2007 Case Management Report. Recurring challenges identified in each of these reports include:

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

In the past few years, additional pressures have required Minnesota to look even more closely, not only at case management, but at the state's entire long-term care delivery system. These pressures include:

- The Centers for Medicare & Medicaid Services (CMS) quality framework focused on desired outcomes of HCBS services.
- The explicit inclusion of freedom of choice as an element of the quality framework, including choice of case manager.
- The 2007 interim final rule from CMS making changes to case management.
- CMS requirements for Minnesota to alter its management of home- and community-based waivers, e.g., eliminate county contracts with providers and establish a statewide rate setting methodology for HCBS services.

In response, the Department began several long-term care reform initiatives that were funded during the 2009 legislature. Combined, these initiatives will fundamentally change Minnesota's long-term care system. Accordingly, they will establish the new environment for the case management system as recommended in this report. The reform initiatives include:

- MnCHOICES – The MnCHOICES initiative will establish a uniform, comprehensive assessment process for determining eligibility for long-term care services, including home- and community-based services, and redefine the components of case management as service and administrative functions.
- Provider Enrollment and Provider Standards Initiative (PEPSI) – PEPSI will create a consistent statewide mechanism for enrolling providers and enhancing provider standards that will bring the state into compliance with federal and state requirements, streamline administrative activities for lead agencies and providers, create a provider verification system for lead agencies to identify enrolled providers, develop and evaluate strategies to monitor the performance of providers in the form of a provider framework and develop a DHS agreement with lead agencies based on newly defined roles.

- Rate-Setting Methodology Initiative (RSMI) – RSMI will create statewide rate setting methodologies for waiver services that will bring DHS into federal compliance, identify components of each waiver service, determine standard values for each service component and establish methodologies to create rates based on service components and individual needs.

(Overviews of MnCHOICES, PEPSI, and RSMI can be found in Appendixes C, D and E.)

### III. PROJECT ACTIVITIES

In response to 2010 legislative requirements, the Department formed the DHS Case Management Reform Work Group. The Work Group included representatives of key stakeholder groups, i.e., counties, disability advocacy groups, service providers, and representatives of agencies which provide contracted case management. In addition, membership included representatives from each of the Department's three major 2009 long-term care reform initiatives work groups (MnCHOICES, PEPSI and RSMI) because these initiatives impact the role and definitions of case management as an administrative function and a service.

The Work Group met in an advisory capacity to the Department and meetings were held every two weeks over a four month period from October 2010 through January 2011. As background for the discussions and to establish a common foundational understanding, the Work Group reviewed and discussed:

- The current case management system in Minnesota.
- The 2007 Case Management Report which grouped recommendations into six principal areas:
  - Standardize and simplify processes,
  - Standardize performance measures and maximize individualization,
  - Increase opportunities for consumer choice of case manager,
  - Regionalize some functions,
  - Simplify Medicaid financing of case management, and
  - Standardize caseload sizes.
- Pertinent laws and rules that govern the provision of case management:
  - The Unitary Residence and Financial Responsibility Statute (MN Statute, Chapter 256G) which specifies when a person enrolled in a social service program administered by DHS remains the financial responsibility of a specific county (included as Appendix F), and
  - MN Statute, Sect. 256B.092, and Rule 9525.0032, which require counties to develop services specific to the needs of persons with developmental disabilities within their county. Rule 9525.0032 also includes the "host county concurrence" provision, which outlines the notification and permission requirements for a person with developmental disabilities to access services in a county other than their county of financial responsibility.

- Data on case management expenditures and county of financial responsibility impacts (included as Appendix G).

Additionally, the following guiding principles for what a restructured case management system in Minnesota should look like were developed in an effort to frame the Work Groups' deliberations:

- A streamlined system with easy access, coordinated management information systems and a central database.
- Expanded consumer choice and self-determination.
- Equity across disability groups and funding streams and lead agencies (access and quality of service; standardized definitions, rules, forms, processes, etc.).
- A clear definition of administrative function and service function.
- Development of, and ongoing education on, performance measures.
- Clear, usable, easy-to-understand consumer information.
- Strong client advocacy role for case managers.
- Flexibility based on clients' needs.

Through this series of meetings, a preliminary response to the 2010 legislative mandate was framed. Upon completion of the Work Group's activities, the Department reviewed and further developed the report recommendations.

As tenets throughout the discussions, it was agreed that case management should remain an essential service in Minnesota, that it should be provided with more consumer choice and self-direction, and that access to case management should not be dependent on a person's funding stream for the service.

Recommendations were developed for each of the three goal areas identified in the 2010 legislation: (1) define, and improve funding for, administrative and service functions of case management; (2) standardize and simplify case management processes, standards, and timelines; and (3) increase consumer choice of case management.

#### **IV. RECOMMENDATIONS**

The 2010 Legislature required the Department to develop recommendations and propose legislation to make changes in case management for persons with disabilities in Minnesota. Specifically, the Laws of Minnesota 2010, Chapter 352, Article 1, Section 27, mandates the Department to:

- (1) Define the administrative and the service functions of case management for persons with disabilities and make changes to improve the funding for administrative functions;
- (2) Standardize and simplify processes, standards and timelines for case management within the Department of Human Services, Disability Services

Division,  
including eligibility determinations, resource allocation, management of dollars,  
provision for assignment of one case manager at a time per person, waiting lists,  
quality assurance, host county concurrence requirements, county of financial  
responsibility provisions and waiver compliance; and

- (3) Increase opportunities for consumer choice of case management functions involving service coordination.

The Department carefully analyzed each of these requirements and developed recommendations to reform the case management system in Minnesota. The following is a summary of the analysis and the recommendations made. These include next steps/implementation recommendations, if any, and associated costs, where applicable, for each of the recommendations.

In addition, the Department recommends that the Work Group continue to meet through 2011 to address implementation barriers, analyze data, etc., and that it expands to include other areas of the Department, i.e., Mental Health, Aging and Adult Service, Children and Family Services. This will allow the Department to more broadly implement the vision of this report while tackling barriers.

## **RECOMMENDATIONS**

### **Separate the functions of and payment for the administration and service of case management; change the name of the service of case management to service coordination.**

As stated in the background for this report, there are two types of activities that are included in case management: the service of case management and the administrative functions. The service of case management includes activities that are performed specifically for the person such as assisting them in finding providers, monitoring those providers, assuring the services are meeting the person's stated goals, etc. Administrative activities include gatekeeping activities such as eligibility determination, service authorization and quality monitoring of the service system.

In Minnesota, case management is bundled, combining the service of case management and administrative functions of case management. Any effort to simplify and streamline case management, including financing of case management, should entail separating the service of case management from the administrative functions. This would promote greater transparency in identifying what is being paid for and from which funding stream.

To succeed, the core administrative functions the state delegates to lead agencies must be clearly identified and distinguished from the service of case management. In addition, it must be clear how the state will pay the lead agencies to perform these administrative functions. Once identified, changes will need to be made to the time studies that collect the information that allows the state to draw down federal financial participation.

The major long-term care reform initiatives authorized by the 2009 legislature (MnCHOICES, PEPSI and RSMI) have been moving in this direction.

The MnCHOICES initiative will increase consistency and equitable distribution of resources statewide by:

- Implementing a new process, standards and a web-based software application to determine a person's eligibility for home- and community-based and other long-term care services.
- Requiring lead agencies (counties, tribes and health plans) to use certified assessors to conduct the assessments and determine eligibility.
- Identifying administrative functions of eligibility determination, service eligibility and level of care.
- Requiring a uniform assessment to determine eligibility for long-term care services.

Work groups for the MnCHOICES initiative have defined the administrative activities of assessments and eligibility determinations and, based on that definition, are now developing a payment methodology that will use the administrative claiming method noted above to secure Federal Medicaid dollars for these activities.

Provider Enrollment and Provider Standards Initiative (PEPSI) will create a consistent statewide mechanism for enrolling providers and enhancing provider standards by:

- Developing consistent and equitable waiver service standards and improved processes to verify provider compliance.
- Enhancing provider standards to improve delivery of services.
- Increasing recipient access to and choice of qualified providers.
- Eliminating use of lead agency contracts with providers and replacing them with a statewide provider agreement.
- Developing statewide methods for lead agencies to monitor providers,
- Integrating existing provider quality assurance and over sight mechanisms.

The Rate Setting Methodology Initiative will establish statewide rate-setting methodologies for home-and community-based waiver services for individuals with disabilities by:

- Identifying components of each waiver service.
- Determining standardized pricing for each service component.
- Creating rate methodologies based on service components and individual needs.

Finally, the term "case management" can be confusing as it refers to both the administrative functions and the service of case management. By separating the administrative functions from the service of case management and renaming the service of case management to service coordination, this would help eliminate the confusion.

**NEXT STEPS:**

- Cross walk the preliminary definitions of the administration and service of case management that were developed by the Work Group with the work of the MnCHOICES and PEPSI initiatives to assure consistency. (The preliminary definitions are included as Appendix G.).
- Assure that all aspects of the administrative functions have been identified and addressed.
- Define payment structure for administrative functions -- Modifications to the time studies are necessary to ensure that the full range of claimable administrative costs are identified and properly attributed to Medicaid.
- Analyze possible changes needed to IT systems within the Department.
- Clearly define the service functions of case management -- This will become more apparent as the administrative functions are defined. Setting a rate for the service of case management will be necessary as well as defining provider qualifications and determining certification requirements.
- Make necessary legislative changes.

**COSTS:** To be determined based on:

- Required modifications to the time studies and IT systems.
- Cost analysis of effects of changes to lead agencies (counties, tribes and health plans).

**Keep case management as a waiver service and develop a targeted case management service for persons with developmental disabilities who are not on a waiver.**

The 2007 Case Management Report outlined the two types of service claiming options for case management (targeted case management and HCBS waivers). Minnesota uses both types. The 2007 Case Management Report recommended that Minnesota drop the coverage of case management from the waivers and use targeted case management exclusively as a way to pay for the service of case management.

Using targeted case management as the sole vehicle to pay for the service of case management requires careful consideration.

- Case management in the HCBS waivers as a service:

This allows for some administrative costs to be covered that otherwise wouldn't, e.g., review and approval of a service plan. If the service of case management is paid exclusively through the targeted case management option, review and approval of service plans will be administrative functions and, as such, the state will need to assure there is an infrastructure in place for the service provider of case management to get approval for any changes needed and the authorization of the service plan.

- Assurance of a person's health and safety:

Minnesota, as are all states, is held to the assurance that a person's service plan reasonably assures the person's health and safety. Case management is a required service in the waivers so that Minnesota can meet that assurance. It will be necessary to identify how this assurance would be met if not through the waiver service of case management.

The 2007 case management report details many of these considerations. While movement in this direction of targeted case management for all case management may simplify financing of case management, it may also cause other problems if not done without fully understanding the impact of the case management system as a whole.

This report's specific recommendation would be to move in this direction and keep the service of case management in the HCBS waivers, for now, while the state does the analysis necessary to determine the advantages or disadvantages of using targeted case management as the service delivery and payment mechanism for the service of case management and develops the various targeted groups and receives the required federal approval.

#### **NEXT STEPS:**

- Decide on which strategies from the 2007 Case Management Report would most effectively move the Department toward implementing the recommendation.
- Lay out the plan to implement and determine interim strategies while transition is taking place.
- Redo the cost analysis of the 2007 case management report; analyze the impact of changes on lead agencies.
- Identify changes needed to the current reimbursement systems both at county and state level.
- Identify populations to target and determine best approach.
- Develop estimate of system modification costs and training costs.

**COSTS:** Estimated costs of development for systems modifications and training need to be established.

#### **Build on current strategies to improve the efficiency in the administration and provision of case management.**

The broad goals of this 2010 legislation priority are to promote equity in the distribution of resources of and access to case management services, create greater efficiency in administration and provision of case management and improve quality.

The 2007 Case Management Report labeled existing case management requirements a "hodgepodge" with different individuals on different timeframes for assessment, planning

and monitoring that result from the multitude of funding streams available for case management.

The 2007 Case Management Report recommendations for greater standardization included:

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

As noted in this report, the Department has made significant progress towards the recommendations noted above. The MnCHOICES initiative will address the assessment issues by creating a uniform assessment process and web based application that will replace the current assessment processes. The MnCHOICES initiative will also provide better data that will allow the Department to establish more consistency in resource allocations.

The Department is pursuing a common service menu as each waiver comes up for renewal, adding services so all are available in the different waivers. To date, the Department has added services to the CADI and TBI waivers that are the same in the DD waiver. Next steps include reviewing, consolidating and redefining the services, as needed, eliminating duplication and allowing distinctions only as necessary.

#### **NEXT STEPS:**

Continue to build on the progress made to date by the Department's reform initiatives (MnCHOICES, PEPSI and RSMI) and pursue opportunities (such as the strategies contained in the Money Follows the Person grant and the Pathways to Employment initiative) to improve efficiency by standardizing and simplifying processes.

**Eliminate Personal Care Assistance from the definition of Excluded Time in Mn. Stat., Chap. 256G.02, subd. 6. Examine the Unitary Residence Act especially as it relates to long-term care services and conduct a study to determine the effect of changes in County of Financial Responsibility and County of Residence.**

MN Statute, Chapter 256G, entitled "The Unitary Residence and Financial Responsibility Act," governs the Minnesota human services system (this is included as Appendix H). It specifies under what circumstances a county would be "financially responsible" for a person in the service system. Since the state requires counties to provide certain services to people whether or not the counties receive reimbursement for those services from the state, the financial responsibility provisions are of great importance to the counties.

Also, 256G.02, Subd. 6, includes a provision for “excluded time.” According to this provision, the time during which a person is living in a specified facility (e.g., a hospital, nursing home, or foster home) or is receiving certain specified services, would be “excluded” for the purposes of determining which county is financially responsible for the person. One of the specified services for “excluded time” status is Personal Care Assistance (PCA) services. Other services include Semi-independent Living (SILS) services and Day Training and Habilitation services.

As an example, if a person who is receiving one of the specified services for excluded time in Hennepin County and moves to Olmsted County, Hennepin County would remain the county of “financial responsibility.” In this example, the person must receive case management and approval for services from Hennepin County (i.e., the county of financial responsibility) even though he or she resides in Olmsted County.

There are a myriad of issues that are involved with changing county of financial responsibility policies. The value of the provisions of the Unitary Residence and Financial Responsibility Act has been debated and continued analysis is needed in order to fully understand the impact of changes. Additionally, any significant changes to it must be vetted thoroughly with appropriate county representatives.

The specific recommendations in this report are limited to eliminating Personal Care Assistance services as an excluded time service and to continue to study the impact of changes in this law.

#### **NEXT STEPS:**

- Amend the Unitary Residence Act by eliminating Personal Care Assistance Services from the definition of Excluded Time in MN Stat., Chap. 256G.02, subd.6. Examine the Unitary Residence Act especially as it relates to long-term care services.
- Conduct a study to determine the impact of any changes in County of Financial Responsibility and County of Residence.

**COSTS:** There would be administrative costs for conducting a study and analyzing the impact of changes.

#### **Change Host County Concurrence to Host County Notification.**

Minnesota began developing home and community-based services in the early 1980’s as a means to downsize and close Regional Treatment Centers (RTCs) for persons with developmental disabilities. MN Rule 9525 (or Rule 185 as it is commonly known) was promulgated to instruct counties on their responsibilities for governing the planning, development and provision of services for this population.

Given this responsibility, and the requirement to assure the health and safety of people with developmental disabilities living in their county, provisions were included in the rule to

assure that counties were aware and in agreement with persons moving into their county to access services.

Host county concurrence states that if a county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility must contact and receive permission from the county of service.

Counties believe host county concurrence allows them to better understand who is or isn't using services developed within their county and the availability of such services. Host county concurrence, according to the counties, also allows them to more effectively manage resources for their residents. Although host county concurrence by law only applies to services for persons with developmental disabilities, many counties have required it across all of their HCBS waiver programs for persons under the age of 65.

Stakeholders and advocates, on the other hand, argue that both host county concurrence as well as county of financial responsibility laws may deny access, do not promote consumer choice and limit a person's right to live wherever they choose.

Changing Host County Concurrence to Host County Notification would mean that the county to which a person wishes to move only would be informed of the impending move; concurrence would no longer be required. The notification process will need to be transparent by including a requirement, for example, that a county has to provide specific and detailed information to another county if an individual is moving to or utilizing services in that county. The process could also specify that an individual's case manager and service provider must assure that his or her needs are met and, in the case of residential services, that the individual is a good fit with the facilities' other residents.

#### **NEXT STEPS:**

- Develop notification process and forms which outlines the process and information necessary for this change.
- Develop necessary legislative language.

#### **Increase opportunities for consumer choice of case management service coordination; develop provider qualifications and a rate for the provision of service coordination and conduct cost analysis of allowing choice.**

The federal government requires states to allow Medicaid beneficiaries to freely select to receive services from qualified providers. In addition, they require states to permit all willing and qualified providers to enroll as Medicaid providers. This includes the service of case management.

Minnesota's framework for the provision of case management requires counties to be solely responsible for who provides case management to eligible persons<sup>2</sup>. The Center for Medicare and Medicaid Services (CMS) has called into question this delivery model because it limits a person's choice of provider. CMS required Minnesota to obtain a §1915(b) waiver (termed a freedom of choice waiver) in order to continue this practice in all of the home and community-based waivers for persons under the age of 65.

Counties may contract out the service of case management and many do; however, the ultimate responsibility lies with the county. Counties that do contract with private case management agencies manage provider standards and quality assurance mechanisms. Each county trains their case management providers and negotiates rates of payment for the services.

Increasing consumer choice would require both an increased number of private case management agencies and an enhanced ability for consumers to make informed choices among the case management options available. Defining the service of case management, developing provider qualification and setting a rate for the service would set the stage for Minnesota to increase choice of case management. The 2007 case management report outlines a phased in approach that could be taken as a starting point for beginning implementation.

This approach needs careful and thorough analysis. Although the 2007 Case Management Report asserts that contracted service coordination is generally less costly on a per-person basis than county-furnished service coordination, it is also important to note that increasing the number of providers may increase access and possibly utilization costs. It will be important to anticipate the impact.

In addition, The Department will need to undertake considerable efforts to move away from the current model to one that has enough qualified providers for individuals to access the service which will entail the development of statewide standards, training and perhaps a certification process and quality assurance mechanisms.

Another consideration is that many private case management agencies also provide other waiver services individuals may receive. There is a potential conflict of interest if the case manager is also the provider of a service because of the vested interest of the service provider to continue to provide the service and the case manager's responsibility to assure the service is being provided appropriately.

To avoid conflict of interest, it is recommended that while private case management providers can also provide other services, they may not provide case management for any individual for whom they provide other services.

Individuals should be fully aware of what to expect when receiving case management services and how much it will cost. Individuals should also be able to have control over

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<sup>2</sup> Except as noted earlier (pg. 7), tribal governments and health plans operate under contract directly with the state.

how often the service of case management should be provided. Although the state should set a minimum (for example, one visit per year), it should be up to the individual, in conjunction with the case manager, to determine how much more contact is needed.

**NEXT STEPS:**

- Continue the work of the Work Group or some similar group with broad representation by counties, tribes and stakeholders.
- Develop provider standards (in collaboration with activities in the Provider Enrollment Provider Standards Initiative).
- Analyze and develop a rate for the service of case management (in collaboration with the Rate Setting Methodology Initiative).
- Develop training and possible certification process for private case management providers.

**COSTS:** Unknown, until the analyses of these recommendations is complete.

## **V. CONCLUSION and LOOKING AHEAD**

The recommendations in this report and that of the 2007 Case Management Report cannot be implemented overnight. The current case management system was developed over a period of decades and, therefore, care must be taken to create the new system. Changes will need to be made over time using a phased-in approach; as with any changes, unintended consequences may occur. It will be important to identify those consequences and mitigate them as needed.

How quickly these changes can be implemented is dependent on the resources provided to the Department for these efforts to ensure that the necessary research, analysis and continued stakeholder input is completed.

## **Appendices**

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**Appendix A: Work group membership**

| <b>Last Name</b> | <b>First Name</b> | <b>Organization</b>                                                    |
|------------------|-------------------|------------------------------------------------------------------------|
| Amado            | Angela            | Institute for Community Integration (ICI)                              |
| Barker           | John Wayne        | MnDACA                                                                 |
| Buhman           | Curtis            | Rate Setting Methodology Initiative (RSMI)/Hennepin County             |
| Conrath          | Milt              | The ARC of Minnesota                                                   |
| Henry            | Anne              | Disability Law Center                                                  |
| Hildebrandt      | Mary              | Local Public Health Association (LPHA)                                 |
| Klinkhammer      | Pete              | Brain Injury Association of Minnesota                                  |
| Kramer           | Matt              | Governor's Council on Developmental Disabilities                       |
| Kunkel           | Peggy             | Association of Residential Resources in Minnesota (ARRM)               |
| Megan            | Lynne             | Minnesota Habilitation Coalition (MnHAB)                               |
| Mohs             | Meghan            | Minnesota Association of County Social Service Administrators (MACSSA) |
| Napoli           | Annie             | Minnesota Association of County Social Service Administrators (MACSSA) |
| Rosenfield       | Bud               | Disability Law Center                                                  |
| Snegosky         | Laurie            | Local Public Health Association (LPHA)                                 |
| Stevens          | Jennifer          | White Earth Nation                                                     |
| Tschida          | John              | Consortium for Citizens with Disabilities                              |

| Last Name  | First Name | Organization                 |
|------------|------------|------------------------------|
| Erkel      | Pam        | Department of Human Services |
| Hayes      | Maren      | Department of Human Services |
| Priester   | Jake       | Department of Human Services |
| Schley     | Elissa     | Department of Human Services |
| Siebenaler | Deb        | Department of Human Services |
| Smith      | Shannon    | Department of Human Services |

## **APPENDIX B: 2007 Legislative Report Redesigning case management services for people with disabilities in Minnesota**

### EXECUTIVE SUMMARY

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

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

### **A. RECOMMENDATIONS**

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

#### **1. Standardize and simplify case management processes**

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

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

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

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

consumers can be increased. With such an information system, inequities between groups, individuals, and counties can be reduced.

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

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

**COSTS:**

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

**2. Maximize individualization while assuring minimum performance standards**

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

**COSTS:**

First, an optimal implementation structure for monitoring performance could be established through the management information system discussed above in Recommendation #1.B.

Second, the meeting of performance measures is also critically tied to caseload size, discussed in Recommendation #6 below.

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

### **3. Increase opportunities for consumer choice of case manager**

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

Two phases are recommended. In the first phase, counties would retain responsibility for gate-keeping, administration and quality assurance while increasing their contracted use of private vendors for service coordination. The first phase would also include developing opportunities for meaningful consumer choice among case managers. In the second phase, the state would allow open enrollment of private vendors (direct contracts with the state) for service coordination functions, further increasing options for consumer choice.

#### **COSTS:**

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

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

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

#### **COSTS:**

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

## 5. Simplify Medicaid financing of case management

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

### **COSTS:**

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

## 6. Standardize caseload sizes

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

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

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

### **COSTS:**

Implementing a 1:40 caseload standard across all four waivers would have a total federal/state Medicaid cost of \$16.3 million and require an additional \$8.2 million in state matching funds, based on the number of waiver participants in 2005. Additional expenditures would be required if that same ratio were applied to persons receiving

case management under Vulnerable Adults and Adults with Developmental Disabilities Targeted Case Management (VA/DD-TCM).

## **B. PROJECT ACTIVITIES**

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

The study was aimed at the following groups:

1. People meeting the definition of developmental disability;
2. People using personal care assistance (PCA) services who are under the age of 65;
3. People using home care services under the age of 65 who have a disability determination.
4. People with traumatic or acquired brain injury;
5. People with physical disabilities or chronic medical condition(s), under the age of 65 who have a disability determination;
6. People in nursing facilities (NF) who are under the age of 65; and
7. People on any of the four disability waivers that are not already mentioned above (Community Alternative Care, Community Alternatives for Disabled Individuals, Traumatic Brain Injury and Developmental Disabilities).

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

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

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

The recommendations contained in this report came from several sources, including reports from Minnesota and other states, federal and national reports, information from national and international experts, input from various Minnesota stakeholder groups,

and interviews of representatives from other states which were recommended for their innovative models.

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

## **C. FINDINGS**

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

National disability experts recommended innovative case management models in other states, and information was collected from twenty other states. Minnesota lags behind some states that have developed innovative data based management information systems to coordinate information and services, and also behind some states that have better-established structures for self-determination and consumer choice. Minnesota is currently similar to several other states in making efforts to streamline and simplify processes across the various disability groups and to maximize services and support in the face of diminishing resources.

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

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

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

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

Each of the recommendations of simplifying Medicaid financing, regionalizing functions, increasing private case management for service coordination and equalizing

performance standards will have a fiscal impact. The impact of each of these reform efforts will need to be monitored and managed. Significant system and case management effectiveness and improvement in performance are intrinsically tied to size of caseloads, adequacy of management information systems, and consumer choice of case manager.

## **Appendix C: MnCHOICES overview**

In 2004, DHS in collaboration with stakeholders began to work on what is currently known as MnCHOICES (formerly known as COMPASS). This new process and data collection tool was developed to ensure greater consistency and access to the right service at the right time across populations that receive Long Term Care assessments. The 2009 Minnesota Legislature approved funding for the Minnesota Department of Human Services, Continuing Care Administration to implement MnCHOICES beginning January 2011.

MnCHOICES will take the place of all Long Term Care assessments that are currently required including:

- Developmental Disability Screening
- Long Term Care Consultation (LTCC)
- Medical Assistance Health Status Assessment for Personal Care Assistance Services
- Private Duty Nursing Assessment

### **MnCHOICES Project Outcomes and Vision:**

MnCHOICES is a new web-based tool using a person-centered approach designed to:

- Allow for timely consideration of support options beyond what is reimbursed through Medical Assistance long-term care programs.
- Combine Long Term Care assessment processes.
- Provide additional data to evaluate outcomes.
- Simplify and standardize face-to-face assessments.

The vision of COMPASS is to have a comprehensive assessment process that supports improvements to both quality and efficiency of:

- Assessment standards and protocols that includes all ages and disabilities.
- Flexibility to address eligibility, payment of service and case management needs.
- Recognition of available informal caregivers and supports.

### **MnCHOICES Project Framework:**

The MnCHOICES initiative is developing standards and protocols, a common web-based data collection tool, and recommendations to best utilize the tools to improve the reliability and equity of service provision, with careful regard given to the possible impact on service funding structures.

The MnCHOICES Project framework is comprised of distinct sub-projects including project Sponsors, Project Owners, a Steering Committee, Project Leads and work groups. The sub-projects within COMPASS include:

**Systems technology:** Designed to provide technology solutions for standardizing the assessment process and collection of assessment data for Long Term Care services.

**Policy revision:** Designed to implement legislative reform which will require policy review, revision and implementation.

**Payment:** Designed to develop a new payment methodology for all processes in the COMPASS business process model.

**Certification and training:** Designed to develop training curriculum and ensure identified assessors are trained and certified within established time lines.

## **Appendix D: Provider Enrollment Provider Standards (PEPSI) overview**

### **Objective:**

To develop statewide consistency in provider standards and provider enrollment processes.

### **Overview:**

The Provider Enrollment and Provider Standards Initiative will develop a common provider enrollment business process across waiver services with increased provider standards and verification in response to the need for transitioning from lead agency contracts with waiver service providers to a consistent statewide approach to address provider standards and qualifications, as well as participant access to services. The development of a statewide approach includes the following:

- Creating a consistent statewide waiver provider enrollment process with consistent and equitable provider standards and improved processes to verify standards
- Developing a directory of enrolled providers that will assure provider standards are met at initial enrollment and are verified on an ongoing basis
- Increasing recipient access to and choice of qualified providers
- Providing a comprehensive quality assurance mechanisms
- Maximizing use of state resources by integrating existing provider quality assurance and oversight mechanisms and evidence of provider qualifications and performance generated via these mechanisms into DHS' provider enrollment system

### **Progress:**

In collaboration the Disability Services Division and Aging and Adult Services Division convened stakeholder work groups to assist with the goals of the provider enrollment and provider standards initiative. Work groups are made up of counties, providers, advocates and state staff.

As of January 1, 2011, DHS in collaboration with work groups have:

- Developed recommendations relevant components of the current HCBS Model Contract Template to move forward in the state provider enrollment process
- Identified the need and criteria for an exception to enrollment
- Recommended refinements to provider standards for **sixteen** unlicensed waiver services
- Developed frameworks for ongoing provider performance and monitoring including:
  - Establishment of provider compliance activities
  - Identification of the methods and processes for review of compliance

### **Future efforts**

In 2011, the Disability Services Division will:

- Finalize compliance review and complaint processes with stakeholder work group
- Establish roles and responsibilities of lead agencies as it relates to evaluation of service capacity and development of services

- Develop an implementation plan that will identify how providers will transition from county/tribal contracts to new enrollment and monitoring structures
- Re-enroll waiver providers to update provider files with current provider information

In 2012 the Disability Services Division will:

- Transition providers from existing county/tribal contracts to an enhanced provider enrollment with the state
- Evaluate operational structures and make changes and enhancements as necessary

In 2013 the Disability Services Division will:

- Operationalize the new enrollment process and ongoing monitoring for provider compliance for all waiver service providers

**PEPSI Website- [http://www.dhs.state.mn.us/dhs16\\_144650](http://www.dhs.state.mn.us/dhs16_144650)**

**PEPSI Email- [DHS.DSD.pepsi@state.mn.us](mailto:DHS.DSD.pepsi@state.mn.us)**

## **APPENDIX E: Rate Setting Methodology Initiative (RSMI) overview**

### **Rate Setting Methodologies Initiative (RSMI)**

In response to the CAC Waiver renewal submitted in 2007, CMS stated that Minnesota's current rate setting methodology for all waiver services (including CADI, DD and TBI) does not assure that payments for these services are consistent with efficiency, economy and quality of care as stated in section 1902(a)(30)(A) of the Social Security Act. CMS informed DHS that a state must have uniform rate determination methods that apply to each waiver service. This is to ensure:

- Payments across all areas of the state are equitable, and
- Any differences in rates are based on factors specified in the methodology or formula based on concrete indices (e.g., difficulty of care or geographic factors).

CMS proposed that DHS create a uniformly applied statewide rate-setting methodology that allows rate variations to capture the individualized nature of services.

The Rate Setting Methodologies Initiative (RSMI) has been undertaken to establish statewide rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities, which includes all services provided under the CAC, CADI, DD and TBI waivers. The rate-setting methodologies for these services must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

This initiative will:

- Bring DHS into federal compliance for the renewal of federal financial participation in the disability waiver programs
- Identify components of each waiver service
- Determine standardized pricing for each service component, and
- Create rate methodologies based on service components and individual needs.

In order to develop standardized rate setting methodologies, DHS engaged other local government, service provider and participant advocacy stakeholders to participate in the development of rate frameworks. Since July of 2009, DHS and involved stakeholders have:

- Reviewed information regarding current and previous rate setting research and methodologies
- Interviewed subject matter experts on rate development and service provision
- Created rate setting methodologies for disability waiver services
- Defined service components to be included in rates for disability services
- Created rate calculations specific to each service which define how service components relate to one another to determine rates
- Determined data sources and gathered data that will be used to populate the rate frameworks

- Begun a comprehensive data collection and analysis process, and
- Completed rate frameworks.

In order to implement the Rate Setting Methodologies Initiative, the Department will:

- Finish determining data to populate rate frameworks
- Create rate ranges based on assessment information
- Connect rate customizations to assessment information
- Conduct impact analysis
- Develop web based technology
- Connect technology to billing systems
- Develop legislative language
- Coordinate stakeholder training and communication
- Manage discovery and remediation issues, and
- Conduct program evaluation

**APPENDIX F: Case management expenditures**

(This data is updated from the 2007 Case Management Report.)

**2009 Expenditures for case management for persons with disabilities**

|   | Type of case management         | Total SFY<br>2009<br>expenditures | Percent of<br>total<br>expenditures | Persons<br>served | Per person<br>expenditures | Federal    | State      | County/<br>other |
|---|---------------------------------|-----------------------------------|-------------------------------------|-------------------|----------------------------|------------|------------|------------------|
| 1 | CAC Waiver                      | 879,808                           | 0.9%                                | 379               | 2,321                      | 439,904    | 439,904    | -                |
| 2 | CADI Waiver                     | 26,226,291                        | 28.0%                               | 16,123            | 1,627                      | 13,113,146 | 13,113,146 | -                |
| 3 | TBI Waiver                      | 2,971,208                         | 3.2%                                | 1,533             | 1,938                      | 1,485,604  | 1,485,604  | -                |
| 4 | Relocation Service Coordination | 839,209                           | 0.9%                                | 933               | 899                        | 419,605    | 419,605    | -                |
| 5 | DD--County Paid                 | 10,837,683                        | 11.6%                               |                   |                            |            |            | 10,837,683       |
| 6 | DD -- CCSA Paid                 | 1,351,617                         | 1.4%                                |                   |                            |            | 1,351,617  | -                |
| 7 | DD-CWTCM                        | 2,048,229                         | 2.2%                                |                   |                            | 1,024,114  | -          | 1,024,114        |
| 8 | DD Waiver                       | 25,970,155                        | 27.7%                               | 14,676            | 1,770                      | 12,985,078 | 12,985,078 | -                |

Case Management Reform for Persons with Disabilities in Minnesota

|    | Type of case management           | Total SFY 2009 expenditures | Percent of total expenditures | Persons served | Per person expenditures | Federal    | State      | County/other |
|----|-----------------------------------|-----------------------------|-------------------------------|----------------|-------------------------|------------|------------|--------------|
| 9  | DD-Other                          | 453,721                     | 0.5%                          |                |                         |            |            | 453,721      |
| 10 | DD-SSTS                           | 11,693,376                  | 12.5%                         |                |                         | 5,846,688  | -          | 5,846,688    |
| 11 | DD-Title XX                       | 1,030,347                   | 1.1%                          |                |                         | 1,030,347  |            |              |
| 12 | VA/DD TCM                         | 9,428,932                   | 10.1%                         |                |                         | 4,714,466  |            | 4,714,466    |
| 13 | Total case management             | 93,730,576                  | 100%                          |                |                         | 41,058,951 | 29,794,953 | 22,876,672   |
| 14 | Medicaid financed case management | 80,057,208                  |                               |                |                         | 40,028,604 | 28,443,336 | 11,585,268   |
| 15 | Total Development Disabilities    | 62,814,060                  |                               |                |                         | 25,600,693 | 14,336,695 | 22,876,672   |

## **APPENDIX G: Case Management Administrative and Service Activities**

### **Administrative**

- Eligibility review for services (diagnosis)
- Screening
- Intake
- Review and authorization of services based on support plan
- Responding to conciliation/appeals
- Annual review of eligibility and quality assurance
- Eligibility determination of waiver/service/program (include MNCHOICES assessment)
- Develop detailed service plan based on resource allocation amount
- Monitor the quality of provider service delivery and case management
- Gatekeeper
- State guardianship

### **Service of Case Management:**

- Implementation of the support plan
- Informing person of service options
- Consulting with relevant medical and service providers
- Assisting person in identifying potential providers
- Assisting person in accessing services
- Coordination of services
- Paperwork to connect
- Visits, phone calls, service coordination
- Advocacy
- I(individual)SP/C(community)SP development and implementation – coordination of needed/identified services – coordinating multiple case managers/need areas
- Recommendation of specific services to be authorized
- Assisting with Medical Assistance eligibility documentation
- Evaluation, review and monitoring of the service plan as needed
- Monitoring individual clients' plan of care
- Individual support plan creation – monitoring
- Appropriate communication with the person's informal and formal support system

## **APPENDIX H: Minnesota Statute, Chapter 256G**

### **Unitary Residency and Financial Responsibility Act**

#### **256G.01 APPLICATION; CITATION; COVERAGE.**

Subdivision 1. **Applicability.** This chapter governs the Minnesota human services system. The system includes the Department of Human Services, local social services agencies, county welfare agencies, human service boards, community mental health center boards, state hospitals, state nursing homes, and persons, agencies, institutions, organizations, and other entities under contract to any of those agencies to the extent specified in the contract.

Subd. 2. **Citation.** This chapter may be cited as the "Minnesota Unitary Residence and Financial Responsibility Act."

Subd. 3. **Program coverage.** This chapter applies to all social service programs administered by the commissioner in which residence is the determining factor in establishing financial responsibility. These include, but are not limited to: commitment proceedings, including voluntary admissions; emergency holds; poor relief funded wholly through local agencies; social services, including title XX, IV-E and section 256E.12; social services programs funded wholly through the resources of county agencies; social services provided under the Minnesota Indian Family Preservation Act, sections 260.751 to 260.781; costs for delinquency confinement under section 393.07, subdivision 2; service responsibility for these programs; and group residential housing.

Subd. 4. **Additional coverage.** The provisions in sections 256G.02, subdivision 4, paragraphs (a) to (d); 256G.02, subdivisions 5 to 8; 256G.03; 256G.04; 256G.05; and 256G.07, subdivisions 1 to 3, apply to the following programs: the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program; medical assistance; general assistance; the family general assistance program formerly codified in sections 256D.01 to 256D.23; general assistance medical care; and Minnesota supplemental aid.

Subd. 5. **Scope and effect.** Unless stated otherwise, the provisions of this chapter also apply to disputes involving financial responsibility for social services when another definition of the county of financial responsibility has been created in Minnesota Statutes.

#### **256G.02 DEFINITIONS.**

Subdivision 1. **Applicability.** The definitions in this section apply to this chapter.

Subd. 2. **Board and lodging facility.** "Board and lodging facility" means a facility that serves as an alternative to institutionalization and provides a program of on-site care or supervision to persons who cannot live independently in the community because of age or physical, mental, or emotional disability.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **County of financial responsibility.** (a) "County of financial responsibility" has the meanings in paragraphs (b) to (f).

(b) For an applicant who resides in the state and is not in a facility described in subdivision 6, it means the county in which the applicant resides at the time of application.

(c) For an applicant who resides in a facility described in subdivision 6, it means the county in which the applicant last resided in nonexcluded status immediately before entering the facility.

(d) For an applicant who has not resided in this state for any time other than the excluded time, and subject to the limitations in section 256G.03, subdivision 2, it means the county in which the applicant resides at the time of making application.

(e) For an individual already having a social service case open in one county, financial responsibility for any additional social services attaches to the case that has the earliest date of application and has been open without interruption.

(f) Notwithstanding paragraphs (b) to (e), the county of financial responsibility for semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660, is the county of residence in nonexcluded status immediately before the placement into or request for those services.

Subd. 5. **Department.** "Department" means the Department of Human Services.

Subd. 6. **Excluded time.** "Excluded time" means:

(a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

(b) any period an applicant spends on a placement basis in a training and habilitation program, including a rehabilitation facility or work or employment program as defined in section 268A.01; or receiving personal care assistance services pursuant to section 256B.0659; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs and assisted living services; and

(c) any placement for a person with an indeterminate commitment, including independent living.

Subd. 7. **Local agency.** "Local agency" means the agency designated by the county board of commissioners, human services boards, local social services agencies in the several counties of the state or multicounty local social services agencies where those have been established in accordance with law.

Subd. 8. **Reside.** "Reside" means to have an established place of abode in one state or county and not to have an established place of abode in another state or county.

### **256G.03 ESTABLISHING RESIDENCE.**

Subdivision 1. State residence. For purposes of this chapter, a resident of any Minnesota county is considered a state resident.

Subd. 2. **No durational test.** Except as otherwise provided in sections 256J.75; 256B.056, subdivision 1; 256D.02, subdivision 12a, and 256J.12 for purposes of this chapter, no waiting period is required before securing county or state residence. A person cannot, however, gain residence while physically present in an excluded time facility unless otherwise specified in this chapter or in a federal regulation controlling a federally funded human service program. Interstate migrants who enter a shelter for battered women directly from another state can gain residency while in the facility provided the person can provide documentation that the person is a victim of domestic abuse and the county determines that the placement is appropriate; and the commissioner of human services is authorized to make per diem payments under section 256D.05, subdivision 3, on behalf of such individuals.

Subd. 3. **Use of Code of Federal Regulations.** In the event that federal legislation eliminates the federal regulatory basis for medical assistance, the state shall continue to determine eligibility for Minnesota's medical assistance program using the provisions of Code of Federal Regulations, title 42, as construed on the day prior to their federal repeal, except as expressly superseded in chapter 256B, or as superseded by federal law, or as modified by state rule or by regulatory waiver granted to the state.

### **256G.04 DETERMINATION OF RESIDENCE.**

Subdivision 1. **Time of determination.** For purposes of establishing financial responsibility, residence must be determined as of the date a local agency receives a signed request or signed application or the date of eligibility, whichever is later. This subdivision extends to cases in which the applicant may move to another county after the date of application but before the grant or service is actually approved.

Subd. 2. **Moving out of state.** A person retains county and state residence so long as the person's absence from Minnesota is viewed as a temporary absence within the context of the affected program. Direct entry into a facility in another state does not end Minnesota residence for purposes of this chapter. Financial responsibility does not continue, however, unless placement was initiated by a human service agency or another governmental entity that has statutory authority to bind the human service agency and is based on a formal, written plan of treatment, or unless federal regulations require payment for an out-of-state resident.

### **256G.05 RESPONSIBILITY FOR EMERGENCIES.**

Subdivision 1. [Repealed, 1996 c 451 art 2 s 61]

Subd. 2. **Non-Minnesota residents.** State residence is not required for receiving emergency assistance in the Minnesota supplemental aid program. The receipt of emergency assistance must not be used as a factor in determining county or state residence.

**256G.06 DETOXIFICATION SERVICES.**

The county of financial responsibility for detoxification services is the county where the client is physically present when the need for services is identified. If that need is identified while the client is a resident of a chemical dependency facility, the provisions of section 256G.02, subdivision 4, paragraphs (c) and (d), apply.

**256G.07 MOVING TO ANOTHER COUNTY.**

Subdivision 1. **Effect of moving.** Except as provided in subdivision 4, a person who has applied for and is receiving services or assistance under a program governed by this chapter, in any county in this state, and who moves to another county in this state, is entitled to continue to receive that service from the county from which that person has moved until that person has resided in nonexcluded status for two full calendar months in the county to which that person has moved.

Subd. 2. **Transfer of records.** Before the person has resided in nonexcluded status for two calendar months in the county to which that person has moved, the local agency of the county from which the person has moved shall complete an eligibility review and transfer all necessary records relating to that person to the local agency of the county to which the person has moved.

Subd. 3. **Continuation of case.** When the case is terminated for 30 days or less before the recipient reapplies, that case remains the financial responsibility of the county from which the recipient moved until the residence requirement in subdivision 1 is met.

Subd. 3a. [Repealed, 1996 c 451 art 2 s 61]

**Subd. 4. Social service provision.** The types and level of social services to be provided in any case governed by this chapter are those otherwise provided in the county in which the person is physically residing at the time those services are provided.

**256G.08 REIMBURSEMENT RESPONSIBILITY FOR COMMITMENTS.**

Subdivision 1. **Commitment proceedings.** In cases of voluntary admission or commitment to state or other institutions, the committing county shall initially pay for all costs. This includes the expenses of the taking into custody, confinement, emergency holds under sections 253B.05, subdivisions 1 and 2, and 253B.07, examination, commitment, conveyance to the place of detention, rehearing, and hearings under section 253B.092, including hearings held under that section which are venued outside the county of commitment.

Subd. 2. **Responsibility for nonresidents.** If a person committed or voluntarily admitted to a state institution has no residence in this state, financial responsibility belongs to the county of commitment.

Subd. 3. **Initiating county responsible.** The initial responsible county retains responsibility when adequate facts are not submitted to provide a sufficient legal basis for the transfer of responsibility.

#### **256G.09 DETERMINING FINANCIAL RESPONSIBILITY.**

Subdivision 1. **General procedures.** If upon investigation the local agency decides that the application or commitment was not filed in the county of financial responsibility as defined by this chapter, but that the applicant is otherwise eligible for assistance, it shall send a copy of the application or commitment claim, together with the record of any investigation it has made, to the county it believes is financially responsible. The copy and record must be sent within 60 days of the date the application was approved or the claim was paid. The first local agency shall provide assistance to the applicant until financial responsibility is transferred under this section. The county receiving the transmittal has 30 days to accept or reject financial responsibility. A failure to respond within 30 days establishes financial responsibility by the receiving county.

Subd. 2. **Financial disputes.** (a) If the county receiving the transmittal does not believe it is financially responsible, it should provide to the department and the initially responsible county a statement of all facts and documents necessary for the department to make the requested determination of financial responsibility. The submission must clearly state the program area in dispute and must state the specific basis upon which the submitting county is denying financial responsibility.

(b) The initially responsible county then has 15 calendar days to submit its position and any supporting evidence to the department. The absence of a submission by the initially responsible county does not limit the right of the department to issue a binding opinion based on the evidence actually submitted.

(c) A case must not be submitted until the local agency taking the application or making the commitment has made an initial determination about eligibility and financial responsibility, and services have been initiated. This paragraph does not prohibit the submission of closed cases that otherwise meet the applicable statute of limitations.

Subd. 3. **Department obligations.** The department shall then promptly decide any question of financial responsibility as outlined in this chapter and make an order referring the application to the local agency of the proper county for further action. Further action may include reimbursement by that county of assistance that another county has provided to the applicant under this subdivision. The department shall decide disputes within 60 days of the last county evidentiary submission and shall issue an immediate opinion. The department may make any investigation it considers proper before making its decision. It may prescribe rules it considers necessary to carry out this subdivision. The order of the department binds the local agency involved and the applicant or recipient. That agency shall comply with the order unless reversed on appeal as provided in section 256.045, subdivision 7. The agency shall comply with the order pending the appeal.

Subd. 4. **Appeals.** A local agency that is aggrieved by the order of the department may appeal the opinion to the district court of the county responsible for furnishing assistance or services by serving a written copy of a notice of appeal on the commissioner and any adverse party of record within 30 days after the date the department issued the opinion, and by filing the original notice and proof of service with the court administrator of district court. Service may be made personally or by mail. Service by mail is complete upon mailing. The commissioner may elect to become a party to the proceedings in district court. The court may consider the matter in or out of chambers and shall take no new or additional evidence.

Subd. 5. **Payment pending appeal.** After the department issues an opinion in any submission under this section, the service or assistance covered by the submission must be provided or paid pending or during an appeal to the district court.

#### **256G.10 DERIVATIVE SETTLEMENT.**

The residence of the parent of a minor child, with whom that child last lived in a nonexcluded time setting, or guardian of a ward shall determine the residence of the child or ward for all social services governed by this chapter. For purposes of this chapter, a minor child is defined as being under 18 years of age unless otherwise specified in a program administered by the commissioner. Physical or legal custody has no bearing on residence determinations. This section does not, however, apply to situations involving another state, limit the application of an interstate compact, or apply to situations involving state wards where the commissioner is defined by law as the guardian.

#### **256G.11 NO RETROACTIVE EFFECT.**

This chapter is not retroactive and does not require redetermination of financial responsibility for cases existing on January 1, 1988. This chapter applies only to applications and redeterminations of eligibility taken or routinely made after January 1, 1988. Notwithstanding this section, existing social services cases shall be treated in the same manner as cases for those programs outlined in section 256G.02, subdivision 4, paragraph (g), for which an application is taken or a redetermination is made after January 1, 1988.

#### **256G.12 STATUTE OF LIMITATIONS.**

Subdivision 1. **Limitation.** A submission to the department for a determination of financial responsibility must be made within three years from the date of application for the program in question.

Subd. 2. **Reimbursement.** The obligation of the county ultimately found to be financially responsible extends only to the period immediately following the date the submission was received by the department. In the case of social service programs only, no reimbursement is required until the financially responsible county has an opportunity to review and act on the plan of treatment according to the applicable social service rules.

Subd. 3. **Exception.** Subdivision 2 does not apply to timely and routine submissions for determination of financial responsibility under section 256G.09.