

Minnesota Case Management Reform

Chemical and Mental Health Services
Administration- Adult and Children's
Mental Health Divisions

Continuing Care Administration –
Disability Services Division

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Minnesota Department of **Human Services**

Legislative Report

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I. Executive summary

This report provides recommendations to redesign Medical Assistance (MA) paid case management services in Minnesota. Past legislative reports focused on opportunities to improve case management services within particular division of the Department of Human Services (DHS). The 2013 report to the legislature, MN Case Management Reform¹, described the effort to redesign all types case management services within multiple divisions at DHS. This 2014 report outlines additional work that is required to consolidate the definitions, activities, standards and rates where appropriate for case management services. Significant works remains in order to make the system more responsive to people who need these services.

DHS included stakeholders from all types of case management services provided in Minnesota for this report. There was general consensus regarding the definition and activities of case management, the training required for case managers, providing choice of service provider and standards for case managers and provider agencies. There was also agreement to preserve differences in individual types of case management services when appropriate. There is significantly less consensus regarding rates and payment for case management services.

Minnesota's current case management system is complex. There are different purposes and target populations affected. This report focuses on case management services for people with disabilities and mental health conditions. Targeted case management for Child Welfare and Vulnerable Adult was excluded because their protective mandates are different from other types of case management services. The recommendations are also not applicable to care coordination provided by managed care organizations (MCO). Stakeholders from the MCOs and internal staff from Health Care Special Needs Purchasing were included in the workgroups. They provided valuable information to the process and the integrated care coordination structure was determined to meet the needs of their members without changes at this time.

The workgroup members realized the need for and complexity of system change that would create significant impact for individual outcomes. The following recommendations are suggested to assure better outcomes for case management services. To achieve system transformation, legislative proposals for the 2015 legislative session will be developed and considered by the administration.

Recommendations

1. Definition:

¹ <https://edocs.dhs.state.mn.us/lfs/Server/Public/DHS-6691-ENG>

and Appendix C

Case management is a service that provides a person with access to planning, referral, linkage, assessment, monitoring, coordination and advocacy in partnership with a person and their family².

A case manager assists with access to and navigation of social, health³, education, vocational and other supports and services based on the person's values, strengths, goals and needs.

2. Case management activities:

- Develop a working relationship between the case manager and person
- Advocacy
- Assessment, including ongoing contact to evaluate effectiveness of the support plan
- Develop a plan of services and supports
- Referral and Linkage
- Monitoring and Coordination of services

3. Standards and Outcome Measures

- DHS will use the current educational standards for case managers. DHS will also consider alternative, but comparable qualifications to assure cultural competence and accessibility of the service.
- DHS will require basic foundation training for case managers that would help case managers understand the definition and activities of their role. DHS would provide training tools to support the knowledge and skills that are needed by case managers.
- DHS will require continuing education for case managers; these requirements would be complimentary of their professional licensure or other continuing education requirements, if applicable.
- DHS will develop and require case management provider agencies to be certified or licensed, including identifying the costs for this.

² Throughout this report, "Person" means the service recipient, parents of minor children and/or legal representative

³ Includes physical health, mental health and substance abuse treatment

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- DHS will develop specific outcomes and performance measures for the service of case management.

4. Choice

- DHS will develop procedures to ensure people are provided meaningful choice of case management service provider. This includes providing them information about:
 - Provider agency mission and values
 - Geographic region of service
 - Availability of bilingual or bicultural case managers
 - Ratings, measures, provider report card, that includes information of personal service experience and satisfaction
- DHS will develop specific information about case management that should be given to the person who is inquiring about the service or when they are determined eligible for the service.
- DHS will require a semi-annual evaluation of the case management services in order to change the service plan as needed.
- DHS will continue to research and analyze what is needed to fully develop choice and identify any needed changes to the structure of case management in Minnesota. DHS will work with stakeholders to ensure these changes are made in partnership with lead agencies.
- DHS will continue to meet with county partners to discuss topics and issues identified in the MACSSA portion paper, Appendix E, as relates to reform efforts.

5. Caseload Size

- DHS will consider a tiered case management service to better address the goals of case management services, and match availability and intensity of service with the needs and goals of the person.
- Establishment of caseload sizes for clinical supervisors of MH-TCM should be further studied and future recommendations made. See Appendix A: CMHSA Mental Health Targeted Case Management Redesign for additional information.

6. Payment Rates and Payment Methods

- DHS will review the current time study methodology for TCM services and modify as needed, or establish a new rates model to reduce the range of monthly TCM rates.
- DHS will reevaluate the county role in the financing of TCM services as part of this review.
- DHS will consider any other systems being developed that may be applicable in the analysis for rate setting methodologies

7. Eligibility, Duplication and Service Gaps

- DHS will consider developing a targeted case management type specific to children with developmental disabilities.
- DHS will consider implementing the recommendations of a previous advisory group process as reflected in Appendix F of this report related to admissions, continuing service and discharge criteria from MH-TCM. The recommendations need review and development of legislative language for consideration.
- DHS will further study the American Indian Mental Health Advisory Council recommendations that the eligibility criteria for MH-TCM be expanded to include people experiencing significant functional impairment due to Post Traumatic Stress Disorder.

II. Legislation

Minnesota Laws 2013, Chapter 63, Section 19. RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN⁴.

(a) By February 1, 2014, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation to:

- (1) increase opportunities for choice of case management service provider;
- (2) define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services;
- (3) provide guidance on caseload size to reduce variation across the state;
- (4) develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process;
- (5) develop reporting measures to determine outcomes for case management services to increase continuous quality improvement;
- (6) establish rates for the service of case management that are transparent and consistent for all medical assistance-paid case management;
- (7) develop information for case management recipients to make an informed choice of case management service provider; and
- (8) provide waiver case management recipients with an itemized list of case management services provided on a monthly basis.

(b) The commissioner shall consult with existing stakeholder groups which include representatives of counties, tribes, disability and senior advocacy groups including mental health stakeholders, managed care organizations, and service providers in preparing the recommendations and language for proposed legislation. The commissioner shall present findings, recommendations, and proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

⁴ <https://www.revisor.mn.gov/laws/?id=63&doctype=Chapter&year=2013&type=0>

III. Introduction

Case management is a service that is provided through Minnesota's Medical Assistance (MA) and through Alternative Care (AC) Program⁵. It is defined in 1915 (g) of the Social Security Act⁶ as a service to assist eligible individuals in accessing needed medical, social, educational and other services. Case management in Minnesota is designed and reimbursed in different ways, as allowed by the Centers for Medicare and Medicaid Services (CMS). One way is to define and target a subgroup to receive case management who have mental illness, developmental disabilities or need to relocate from an institution. Another way is as a service through home and community based waivers and AC.

The 2013 report to the legislature, MN Case Management Reform⁷, described the effort to redesign all MA paid case management services within multiple divisions at the Department of Human Services (DHS). This reflected the mandate from 2012⁸ which required DHS to consolidate standards, rates and definitions of different types of case management services when possible.

Current case management system

Case management is provided through different mechanisms across health and social services. Minnesota provides access to case management in many ways to support people who have varying needs. This has allowed case management to evolve through different programs as well, which has created a complex and somewhat fragmented case management delivery system.

Minnesota has a county-based case management service infrastructure. State law specifies that counties provide case management services⁹. The counties may choose to subcontract case management services to community providers. Federally recognized tribes who reach agreement with DHS may also provide case management services.

Minnesota also utilizes managed care organizations (MCO) model to purchase and deliver services. For example, Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) are health care programs that combine separate health programs and support

⁵ http://www.dhs.state.mn.us/id_006284#

⁶ http://www.ssa.gov/OP_Home/ssact/title19/1915.htm

⁷ <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6691-ENG> and Appendix C

⁸ <https://www.revisor.mn.gov/data/revisor/law/2012/0/2012-216.pdf>

⁹ <https://www.revisor.mn.gov/statutes/?id=256B.49> ;

<https://www.revisor.mn.gov/statutes/?id=256B.0915> ;

<https://www.revisor.mn.gov/rules/?id=9520.0903>

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services into one health care package for people over the age of 65. The programs provide care coordination, which is similar to case management, but provides a more comprehensive service that encompasses both acute care and long term services and supports. People enrolled in MSHO and MSC+ are assigned a care coordinator regardless of their service needs or waiver status. Since 2009, MH-TCM has been included in the benefit set for those who enroll with MCOs under Medical Assistance.

Reform efforts

Efforts to reform case management have been ongoing and the topic of many legislative reports over the last decade. The complexities of how the service is paid for and administered across the service system make it difficult to make the service more consistent across populations. In addition, the federal government is offering new opportunities to integrate and coordinate health care and long term services and supports. These programs provide care coordination within a health care system. Minnesota is engaged several in efforts to design Accountable Care Organizations¹⁰ including the Medicaid Accountable Care Organization, Integrated Health Partnerships (formally Health Care Delivery Systems)¹¹ and also Health Care Delivery Systems¹². In addition, Health Care Homes¹³ have been implemented over the past several years. Currently the DHS Health Care and CMHSA are in the process of planning for the development of health homes specifically for children with severe emotional disturbance and adults with serious mental illness. All are examples of ways in which DHS is working to partner with providers and lead agencies to develop systems of care and payment models that are responsive to local needs and conditions, while also achieving the goal of improving the health of the MA population, controlling costs and improving the experience of care.

The 2011 case management legislative report¹⁴ provided recommendations to reform only the case management services administered in the Disability Services Division. Some of the recommendations have been implemented, such as separating the administrative or gatekeeping parts of case management from the ongoing service of case management that assists a person to access services. One of the recommendations in the 2011 report was to continue the workgroup and include all of the case management services provided across DHS programs and services.

DHS expanded the stakeholder groups to include representation across all of DHS divisions that administer different types of case management listed on Appendix B, which include:

¹⁰ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>

¹¹ http://www.dhs.state.mn.us/dhs16_161441

¹² <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-02-28.html>

¹³ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>

¹⁴ <http://archive.leg.state.mn.us/docs/2011/mandated/110488.pdf>

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- Child Welfare-Targeted Case Management (CW-TCM)
- Children’s Mental Health Targeted Case Management (MH-TCM)
- Adult Mental Health Targeted Case Management (MH-TCM)
- Vulnerable Adult/Developmental Disability Targeted Case Management (VA/DD-TCM)
- Relocation Service Coordination (RSC) Targeted Case Management
- Home and Community Based Services (HCBS) Waiver Case Management
- Managed Care: Care Coordination for seniors on MSHO and MSC+

The report to the legislature in 2013¹⁵ included recommendations related to a case management service definition, standards, continuing education requirements, and training. While significant progress was being made to redesign all types of case management, however more work was needed. The report included a recommendation to continue working on case management redesign with the stakeholders.

The internal and external workgroups, continued to collaborate and provide expertise to inform the effort. The Case Management Reform Workgroup included counties, tribes, MCOs, advocacy groups and service providers. In addition, CMHSA convened an advisory group, the Mental Health Targeted Case Management Redesign Advisory Workgroup to address specific topics and issues. Discussion and input of the MH-TCM Reform Advisory Group can be found in Appendix A. Both workgroups served in an advisory capacity to DHS. Participants are listed in Appendix D.

The workgroup participants reviewed information about the definition, activities, eligibility, provider standards and rates for all the different types of MA case management. The goal was to understand the similarities, differences and inconsistencies across case management services and make recommendations for redesigning the system.

The goals for case management reform are to:

- Increase recipient understanding of case management services
- Avoid duplication and redundancy
- Increase choice and self-direction for recipients
- Improve accountability in the provision of case management

¹⁵ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6691-ENG>

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- Design and implement consistent case management provider standards
- Develop outcomes and increase quality improvement strategies for case management services
- Manage limited resources and establish rates for services that are transparent and consistent

Child Welfare and Vulnerable Adult Targeted Case Management

The workgroups examined at all types of MA case management services. It was noted that while some of the case management types readily fit the agreed-upon definition of the service include on page 7, there are also types of case management services that support adults and children who are at risk of maltreatment.

Child Welfare Targeted Case Management (CW-TCM) and Vulnerable Adult Targeted Case Management (VA-TCM) are unique from other case management services. Recommendations included in this report and developed by the stakeholders for case management redesign are not intended to be applied to children receiving CW-TCM or vulnerable adults receiving VA-TCM.

The eligibility criteria for this type of case management:

- CW-TCM services are given to children under age 21 who have been assessed to be at risk of maltreatment¹⁶; at risk of out-of-home placement¹⁷; or in need of protection and services¹⁸.
- Vulnerable Adults (VA) in need of protection may be eligible for Targeted Case Management (TCM) Services¹⁹.

County agencies and tribes in the American Indian Child Welfare Initiative (AICWI) are responsible for conducting investigations and protective services for suspected maltreatment of children. County agencies are also responsible for these items for vulnerable adults. The county and the AICWI tribes are required to provide case management to those children as needed during the course of an investigation or placement²⁰. County agencies are required to provide these protective services to vulnerable adults²¹. Additionally counties must provide protective services to children and adults regardless of whether or not they are eligible for MA and the

¹⁶ Minnesota Statutes section 626.556

¹⁷ Minnesota Statutes 260C.212

¹⁸ Minnesota Statutes 260C.007

¹⁹ Minnesota Statutes 256B.0924

²⁰ Minnesota Statutes 626.556, Subd.10

²¹ Minnesota Statutes 626.557 and 626.5572

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county social service agency is able to claim for the TCM service. Counties must pay the 50% non-federal share for CW-TCM and VA-TCM and they must pay for those people who would not be eligible for reimbursement under MA.

It is for these reasons that the recommendations of this report do not include changes to either CW-TCM or VA-TCM at this time.

This report is submitted to the Minnesota Legislature pursuant to Minnesota Laws 2013, Chapter 63, Section 19. It describes the discussion and recommendations of many stakeholders. Each legislative mandate has been included within the report and will be found in the headings. DHS is committed to a broad approach and a shared vision to improve case management services in Minnesota. The final recommendations reflect the shared direction that will be supported by the Continuing Care and CMHSA.

IV. Defining the Service of Case Management

A. Definition of case management

The Center for Medicare & Medicaid Services defines case management services as activities that are designed to help the recipient in gaining access to needed health, social, educational, vocational, and other necessary services and supports. The definition below was written to be used for all types of case management services in Minnesota. The report to the legislature in 2013 recommended the following as a service definition for all case management services, with the exception of CW-TCM and VA-TCM as previously noted.

Case management is a service that provides a person with access to planning, referral, linkage, assessment, monitoring, coordination and advocacy in partnership with a person and their family.

A case manager assists with access to and navigation of social, health²², education, vocational and other supports and services based on the person's values, strengths, goals and needs.

The current case management system has differing described expectations of a case manager that are specific to the type case management they are providing. This common definition of case management would allow people to understand what they can expect from the service of case management, can readily encompass all case management types and may reduce duplication of services. For example, it would be possible for person to work with one case manager even if eligible even if they are eligible for multiple types of case management.

B. Activities of case management

The workgroups also agreed to a common list of case management service activities:

- **Working relationship between the case manager and person**
- **Advocacy**
- **Assessment, including ongoing contact to evaluate effectiveness of support plan**
- **Developing a plan of services and supports**
- **Referral and Linkage**
- **Monitoring and Coordination of services**

²² Includes physical health, mental health and substance abuse treatment

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The overarching priority of any case management activity should be person-centered and empowering for the person. The person should direct what services they want to meet their goals. Case management services can be provided directly to a person, to parents of minor children or other legal representatives. The case manager is a partner to align the person's preferences to meet their health and safety needs.

The working relationship between the person and the case manager is important for all case management activities. A partnership needs to be formed to empower the person and support their choices. Building rapport and trust is an activity that happens during all case management activities. A case manager can be the supportive hub for assisting the person with navigating other services and working with other professionals. The case manager needs to discuss and document their role with the person and in the plan including the expectations, boundaries, goals and closure process if services are no longer needed.

Another activity is the process of ongoing assessment. The case manager is responsible to continually monitor and assess whether the person's service plan is consistent with their current needs. These check-ins can support the process of developing and changing the plan for service and supports according to a person's needs and choices. At any time the case manager may need to connect the person with services to meet goals or needs. This referral and linkage activity requires awareness of the other programs and services that exist in the community. The case manager can navigate an often complex service system on behalf of the person to ensure successful supports.

Successful outcomes also require monitoring of services and supports. The case manager needs to ensure that the services are working well. When there are barriers to helping a person meet their goals, a case manager has to advocate on behalf of the person and empower them to advocate for themselves.

Recommendations:

- The common definition should be adopted in statute.
- People receiving case management services will be given the definition and the list of activities they can expect to be provided by their case managers.
- DHS will require case managers to discuss their role with the person they are serving, including expectations, boundaries and activities they may perform on behalf of the person, whether in person or in their office.
- Information that is given to the recipient will:
 - Be in a standardized form from DHS
 - Be given to the person at the start of the service
 - Describe the service activities, responsibilities and role of the case manager

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- Show activities that will be done directly with the person and those that are done indirectly on their behalf to support their service plan
- Describe the role and responsibilities of the person receiving case management
- Include appeal rights and the process to file an appeal
- Be provided and reviewed at least semi-annually

V. Statewide case management standards and quality

The workgroups also agreed that a common foundation of standards also needed to be developed. Case management reform will ensure that the service of case management be consistent and driven by providing meaningful outcomes for people.

The key goals of creating standards are to:

- Have consistent foundation standards for those delivering case management services
- Allow an additional level of standards to support unique populations and/or types of case management services
- Increase provider enrollment to support choice for case management services
- Improve monitoring statewide to ensure consistency
- Provide quality case management services

A. Service standards

Individual Case Manager Standards

There are no consistent standards for individual case managers. Generally, the baseline educational requirement for case managers is a bachelor's degree in social work, nursing, psychology, sociology, habilitation and rehabilitation services, or closely related field. There are variations regarding initial training and continuing education and training. For example, case managers who work with people with developmental disabilities must complete twenty hours of continuing education each year²³. Waiver case managers not serving those on the DD waiver have no continuing education requirements. MH-TCM requires forty hours of initial training for new case managers without 2,000 hours of supervised experience in delivery of mental health services and initial supervision of an hour a week. Case managers with the 2,000 hours of supervised experience must receive thirty-eight hours of supervision per year and thirty hours of continuing education every two years.

Other Individual Standards

The workgroups also discussed options for including people who may not meet the educational requirements, but may have experience and knowledge to be a case manager. MH-TCM has a para-professional Case Management Associate (CMA) position to assist with implementation of service and support plans. CMAs that acquire more than three years of experience will then be qualified as a case manager. This CMA position does not require a bachelor's degree, but requires additional training and supervision. Also, the CMA position was created to recognize

²³<https://www.revisor.mn.gov/rules/?id=9525>

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the service value of recovering peers and caregivers and to create a career ladder to becoming a case manager. While the CMA position exists, it is not being utilized by MH-TCM providers. Additional information is needed to understand the reasons for lack of utilization and if it should continue to be an option.

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

Lead agencies can provide case management services or sub-contract to private case management agencies. These organizations ensure that their individual case managers meet the educational, initial training and continuing education requirements.

Training

Case managers who are new to the MH-TCM for adults are provided with an initial web-based training. These online modules provide them with a foundation of the knowledge and skills required to provide case management services. This model for training is recommended for all case management types. The training should enhance CM skills, improve consistency in how people's needs are met and highlight areas of practice that are effective and promising. Each case management type could also have additional levels of specialty training that may be required. Case manager training should include information about services and supports that may be available to the clients they serve in order to ensure case managers have broad knowledge to support their role in referral, advocacy and access.

It is recommended that continuing education be required for all types of case management. Ongoing training requirements would enhance skills, expand their knowledge base, including knowledge of support options and best practices, improve consistency in the activities of case management and update best practices, thereby improving quality.

Case Management Provider Agency Standards

There is no statewide certification or licensure of providers. In general, case management providers must be enrolled as an MA provider and meet general MA provider eligibility standards which are not specific to the service of case management.

There are many provider agencies that contract with counties, tribes and MCOs to provide case management; however, there limited statewide standards for the service. Expectations of those provider agencies are identified in the individual contracts that are held by the lead agency.

The workgroups discussed requiring case management provider agencies to be certified or licensed. This will create consistency in the service across the state. It will assist DHS to:

- Ensure access to consistent service
- Verify compliance with case management service standards

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- Implement quality outcomes and measures
- Provide technical assistance and support
- Provide people with a resource to resolve disputes and/or complaints

This DHS certification process will require exploration of the best options. DHS would need to consider the administrative burden and cost with the benefits. However, a certification for case management providers would be in line with the initiative for Home and Community Based Services Waiver Provider Standards²⁴, which is creating a system that standardizes provider qualifications and strives for improving the quality of services. The CMHSA has current provider certification processes for several mental health services: Adult Mental Health Rehabilitation Services, Assertive Community Treatment, Children's Therapeutic Services and Supports, Youth Assertive Community Treatment and Dialectical Behavior Therapy.

B. Quality measures

In addition to ensuring there are consistent standards for case managers and case management providers, the workgroups discussed the desired outcomes of the service. They wanted to ensure that the outcomes were meaningful to those who provide and receive the service of case management.

Currently, there are limited statewide quality outcome measures for individual case managers or provider organizations regardless of case management service type. The current practice has been to describe participant program enrollment, caseload figures, financial billing and reimbursement for services. There is limited regular monitoring of case management service standards in MA paid programs. MCOs that contract with Minnesota Health Care Programs are required to regularly monitor their case management providers to ensure compliance with service standards.

Improved measurable standards and outcomes will be developed from the common definition of the service of case management. The outcomes must address the unique needs and goals of individual populations. Without these measurable standards for performance and outcomes, the system lacks:

- Clear expectations for participants and their families and authorized representatives
- Sufficient data for reporting
- Standards for quality assurance and accountability
- Ability to enforce policies

Available Data

²⁴ http://www.dhs.state.mn.us/dhs16_172393

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In 2005, the Continuing Care Administration began the Waiver Review Initiative²⁵. This initiative completes regular audits of the lead agencies' administration of HCBS waivers, which includes case management services. The goals of this initiative are to monitor compliance with state and federal requirements, identify promising practices, and track local improvements. Quality measures could be developed using the data from the Waiver Review Initiative that would be useful across any population that utilizes case management services.

The Continuing Care Administration will be conducting participant experience surveys²⁶ in the future. In addition, the State Quality Council²⁷ is working in partnership with the Continuing Care Administration to recommend enhancements to the Long Term Services and Supports system. Including case management would add additional data to assist in developing performance measures.

Quality measures and results should be accessible to people receiving case management services and people who provide the service. It was proposed that DHS develop an electronic reporting system for case management service information and measures. Funding for the development, maintenance and for staffing would be needed for this system. The options and financial costs of this recommendation would need to be evaluated.

Recommendations:

- DHS will use the current educational standards for case managers. DHS will also consider alternative, but comparable qualifications to assure cultural competence and accessibility of the service.
- DHS will require basic foundation training for case managers that would help case managers understand the definition and activities of their role. DHS would provide training tools to support the knowledge and skills that are needed by case managers.
- DHS will require continuing education for case managers. These requirements would not be in addition to, but complimentary of, their professional licensure continuing education if applicable.
- DHS will explore the best options for case management providers to be certified or licensed; this would include identifying the costs for this.
- DHS will develop specific performance measures and outcomes for the service of case management.

²⁵ <http://www.minnesotahcbs.info/>

²⁶ <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6764-ENG>

²⁷ http://www.dhs.state.mn.us/dhs16_165559

VI. Increasing choice for case management provider and supporting informed choice

CMS includes person-centered service planning and delivery in the HCBS quality framework²⁸. Having a broad network choice of case management providers is an important element of a system that supports self direction and independence.

Case management services are currently provided through lead agencies which includes, counties, tribes and managed care organizations. Disability Services Division has a federally approved 1915 (b) Waiver for HCBS case management services which will expire in March 2015. This waiver allows Minnesota to administer case management for the waiver programs through county based health and social services programs. This authority includes these waivers: Brain Injury (BI), Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Developmental Disabilities (DD) and Elderly Waiver (EW) not provided through an MCO.

Changes in statute²⁹ have separated the administrative, eligibility and gatekeeping functions of case management from the service of case management. The MnCHOICES assessment process is facilitating this change, and will take the place of other assessments that are currently used for determining eligibility for waiver programs, AC program, personal care assistance and private duty nursing. An assessor will gather information and make eligibility determinations related to institutional level of care, programs and services and develop an initial Community Support Plan.

The case manager will use the assessment and Community Support Plan to facilitate the support planning process with the person, and finalize the Coordinated Service and Support Plan,³⁰ as well as discuss the ongoing activities of case management with the person. Although the current case management system involves services provided by lead agencies, some counties and MCOs have contracted with community organizations to assist in providing case management. Advocates promoting an expansion of case management providers want to ensure that people receiving case management are able to choose a provider that will meet their needs and change providers if they choose.

There are concerns about providing choice of case management provider statewide. Because Minnesota counties can vary greatly in population, geographic size and economic status, counties with small populations may employ fewer case managers than larger counties. Small counties are concerned about their ability to continue to provide case management when expanding case

²⁸ http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/d_007075.pdf

²⁹ <https://www.revisor.leg.state.mn.us/statutes/?id=256B.092> and <https://www.revisor.mn.gov/statutes/?id=256B.49>

³⁰ See Minnesota Statutes, section 256B.0911 for a description of a Community Support Plan, and sections 256B.0913, 256B.0915, 256B.49 and 256B.092 for a description of a Coordinated Service and Support Plan.

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management provider network. Other counties are concerned about attracting independent providers, especially in rural areas of the state. A policy statement³¹ was shared by Minnesota Association of County Social Service Administrators regarding their concerns in changing case management services. Appendix E explains the concerns by the county that need to be considered if an expansion of the case management provider network is implemented.

Finally, access to assessment, eligibility, provider and other program information is also necessary for a case manager to efficiently perform the service. Private providers do not have access to information systems and technology that are used in the activities case management. DHS is considering options to allow case management provider organization to have access to information systems, for example, the Social Service Information System.

Recommendations:

- DHS will develop procedures to ensure people will be provided meaningful choice of case management service provider. This includes giving them information about:
 - Provider agency mission and values
 - Geographic region of service
 - Availability of bilingual or bicultural case managers
 - Ratings, measures, provider report card, that includes information of personal service experience and satisfaction
- DHS will develop specific information about case management that should be given to the person who is inquiring about the service or when they are determined eligible for the service.
- DHS will require a semi-annual evaluation of the case management services in order to change the service plan as needed.
- DHS will continue to research and analyze what is needed to develop choice and the resulting changes to the structure of case management in Minnesota. DHS will work with stakeholders to ensure these changes are made in partnership with lead agencies.
- DHS will continue to meet with county partners to discuss topics and issues identified in the MACSSA potion paper, Appendix E, as relates to reform efforts.

³¹ Appendix E

VII. Guidance on caseload size

Currently, case managers providing MH-TCM for both adults and children have mandated caseload size limits. For all other case management types, individual lead agencies determine the caseload sizes for their staff. The lead agency has to consider the amount of full-time staff, reimbursement and the amount of time that a recipient may need. There can be different levels of complexity for each person's service needs and that can affect the case manager's time. It was agreed that case managers should have reasonable caseload sizes so they are able to adequately work in partnership with the person.

Reasonable caseload limits for case managers has been described as one of the best tools to assure quality of case management services³² by allowing the case manager to be proactive with the person's needs. As an example, if caseloads are too large, case managers are only able to be reactive to crisis situations. The mandated average caseload size for MH-TCM services are:³³

- Adult MH-TCM= 30 people per full time case manager
- Children's MH-TCM= 15 people per full time case manager

The MH-TCM workgroup agreed that caseload size limits are important to providing quality services and do not need to be changed at this time. However, the group had concerns for the work load limits for clinical supervisors. Each case manager must have ongoing monthly clinical supervision but there is no rule or standard for how many case managers can be overseen by one supervisor. Clinical supervision ensures the appropriateness of assessment and the plan for services. The supervisor needs to have adequate time to provide guidance and support to the case manager. See Appendix A: CMHSA Mental Health Targeted Case Management Redesign.

In addition to the number of people served by a case manager, there was discussion in workgroups about the intensity of the service need and its impact on a case managers overall workload. For example some people may need minimal amounts of case management while others may need contact with their case manager on a daily or weekly basis. So looking at just a number of people on a case load may not take into account the intensity of service that may be required by a person. The workgroup then considered "tiering" case management as a tool to allow flexibility in the size of a case manager's case load.

The DHS Case Management Reform workgroup thought an effective tiered case management system would be:

- Discussed by the person and their case manager
- Based on the person's assessed needs, strengths, goals and preferences

³² Rapp, C.A. & Goscha, R.J. *The Strengths Model: Case Management with People with Psychiatric Disabilities*. Oxford University Press, 2006. Pp 227-228

³³ Minnesota Administrative Rule, 9520.0903 Subp. 2.

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- Individualized in the plan as to the frequency and duration of contact
- Flexible to changing circumstances or health needs

Recommendations:

- DHS will consider a tiered case management service to better address the goals of case management services, and match availability and intensity of service with the needs and goals of the person.
- Establishment of caseload sizes for clinical supervisors of MH-TCM should be further studied and future recommendations made. See Appendix A: CMHSA Mental Health Targeted Case Management Redesign for additional information.

VIII. Establish transparent and consistent case management rates

A. Current system

The current system for setting case management rates has led to variations throughout the state as well as between programs.

Targeted case management is defined in §1915(g) of the Social Security Act, and permits states to target a subset of Medicaid beneficiaries to receive the service as a state plan benefit³⁴. TCM is a state plan service and an entitlement to people who are receiving MA and eligible for the service. Minnesota has several targeted case management groups:

- Vulnerable Adults and Adults with Developmental Disabilities (VA/DD-TCM)
- Child Welfare Targeted Case Management (CW-TCM)
- Mental Health Targeted Case Management for Children and Adults (MH-TCM)
- Relocation Service Coordination (RSC) Targeted Case Management

Case management can also be a service that is provided in HCBS waiver programs under §1915(c) of the Social Security Act. In Minnesota, people enrolled in an HCBS waiver program are required to receive case management as one of the covered services. Minnesota's HCBS waivers include:

- Community Alternatives for Disabled Individuals (CADI)
- Brain Injury (BI)
- Community Alternative Care (CAC)
- Developmental Disability (DD)
- Elderly Waiver (EW)
- Alternative Care (AC)³⁵

Targeted case management

The basic rate methodology that was approved by CMS for county-provided TCM is based on a time study of case management activities, the associated costs of providing case management and the number of recipients. At least one qualifying case management visit must be provided to the person during the month. Rates are recalculated annually and have significant differences

³⁴ http://www.chcs.org/usr_doc/CMS_Medicaid_Targeted_Case_Management_Rule.pdf

³⁵ A non-waiver state program that follows EW requirements and receives 50% federal financial participation; http://www.dhs.state.mn.us/id_006284#

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between counties. The exception is for Relocation Service Coordination, which has a set rate and is billed in 15-minute increments.

Waiver case management

The service of case management is required to be provided to individuals participating in HCBS waiver programs. Waiver case management has a set rate, is prior authorized as part of the Community Support Plan and included under the HCBS budget, and is billed in 15 minute units. Rates change only if approved by the Legislature.

Other rate calculations

Tribal nations providing MH-TCM to members of the tribe are reimbursed per encounter by a rate established by the federal government.

In pre-paid MA model, an MCO receives a monthly capitation amount to manage health care services for a person. The MCO pays MH-TCM or MSHO care coordination service providers a contracted rate. At least one qualifying case management visit must be provided to the person during the month.

In addition to the various rate methodologies, the funding for the case management system varies as well. Minnesota receives federal funding for providing MA and AC. The federal matching rate is 50% for MA and AC services. The state pays the non-federal share for waiver case management, RSC and those who receive services through an MCO. However for MH-TCM and VA/DD-TCM recipients under MA, the counties fund the non-federal share with local tax levies and limited state grant funds.

Counties are also responsible for provision or payment of TCM for eligible individuals who are not insured or are under-insured. Case management is also mandated for people with developmental disabilities³⁶. Any person, who meets the eligibility for this type of case management and requests it, must receive it. However, these case management services are only reimbursable through MA if the person is eligible for the DD waiver or VA/DD-TCM. For adults not eligible for MA or for children not on a waiver or on MA, counties must provide case management with their county tax dollars.

MH-TCM services to eligible individuals in the expansion populations for Medicaid under the Affordable Care Act³⁷ are funded currently at 100% federal funding for three years and 90% federal funding thereafter³⁸.

³⁶ Minnesota Rule 9525³⁶, parts .0004 to .0036

³⁷ Affordable Care Act, Section 2001 (a) (1) (as amended by section 10201)

B. Possible options

The workgroup participants explored one MCO's MH-TCM model that reimburses service providers based on the amount of time the case manager spends on activities with each person. This MCO pays for MH-TCM services based on three levels of service activities that are based on the time that a person receives from a case manager. The case manager is able to provide low, medium or high intensity services, depending on a person's needs during the month. This allows flexibility for the person who may need more or less support from the case manager in any given month.

The new Disability Waiver Rates Framework³⁹ was explored as an option for establishing rates for waiver case management services and RSC. The framework takes into account the salary and benefits costs of staff, the administrative cost and other expenses to determine a service rate. The workgroup would like further exploration and analysis of that option.

The workgroup agreed that any rate system for case management services should be:

- understood by the person receiving the service
- allow flexibility and changes in frequency of case management
- support organizations to hire qualified staff
- transparent with rate methodology
- more comparable across public and private case management providers

It was determined however, that any changes to the case management reimbursement system would take a great deal of financial analysis and implementation planning. The impact of changing the funding system need to be discussed and evaluated before a rate that is consistent and transparent for all case management can be determined.

Recommendations

- DHS will review the current time study methodology for TCM services and modify as needed, or establish a new rates model to reduce the range of monthly TCM rates.
- DHS will reevaluate the county role in the financing of TCM services as part of this review.
- DHS will consider any other systems being developed that may be applicable in the analysis for rate setting methodologies, for example, the Disability Waiver Rate System⁴⁰ framework.

³⁸ http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_177289.pdf

³⁹ http://www.dhs.state.mn.us/dhs16_144651

⁴⁰ http://www.dhs.state.mn.us/dhs16_144651

IX. Eligibility, duplication and service gaps

The case management system can be complex and confusing for people who use the services. The challenges include overlapping eligibility for programs and variations in rules, standards and reimbursement from program to program. Different types of case management services are provided through several different divisions of county social services, tribes, MCOs and contracted providers. These factors may lead to multiple case managers working with the same person.

A. Background/Current

The work groups discussed the current eligibility criteria for the different types of case management services. The current system uses disability diagnosis to determine if a person can access the service. The work groups discussed that the goal should be to provide case management services to people based on their need for the service. The frequency and duration of case management should depend on a person's need and preferences.

Eligibility for case management varies depending on the program. TCM is a state plan service that provides service to specific targeted populations. Minnesota has defined the target populations in the Medicaid state plan.

HCBS waiver programs are not state plan services. They are provided under §1915(c) authority of the Social Security Act, which allow states to provide services that are alternatives to institutional care. Because HCBS waivers are not entitlement services, there may be waiting lists for these programs and therefore, waiting for case management services.

For persons with developmental disabilities, counties are required to provide the service of case management. This requirement is mandated in Minnesota Rule 9525⁴¹, parts .0004 to .0036. Any person, who meets the eligibility for this type of case management and requests it, must receive it. However, these case management services are only reimbursable through MA if the person is eligible for the DD waiver or VA/DD-TCM. For adults not eligible for MA or for children not on a waiver or on MA, counties must provide case management with their county tax dollars. This results in inconsistencies across the state in the provision of mandatory case management for persons with developmental disabilities.

The case management report to the legislature from 2011⁴² recommended developing a targeted case management service for children with developmental disabilities who are on MA, but not on a waiver program. As noted above, this case management service is mandated but due to the funding mechanism is not consistent statewide. This can create a burden on the whole county case management service system.

⁴¹ <https://www.revisor.mn.gov/rules/?id=9525>

⁴² <http://archive.leg.state.mn.us/docs/2011/mandated/110488.pdf>

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In order to determine eligibility for case management for people with developmental disabilities or MH-TCM, a formal diagnostic assessment must be completed. This step can cause gaps in the provision of service due to high demand for mental health professionals⁴³. In many areas of the state, it can take months to complete the additional assessments to determine eligibility. Some counties shared that they provide MH-TCM immediately to those who appear to meet the basic eligibility criteria under a presumptive status⁴⁴. The counties are able to meet the needs of the person while the diagnostic assessment is obtained. If the person is not determined eligible, the lead agency does not receive reimbursement for the provided services. However, this may still cause inconsistencies because counties may not want to risk not being paid for the service they provide or may not have the funding to provide the service without assurance of being reimbursed.

In the MH-TCM Advisory Workgroup, there were discussions that many people don't have the "right diagnoses" to meet the current criteria for MH-TCM. The current diagnostic criteria for eligibility for adults includes Schizophrenia, Bipolar disorder, Major Depression or Borderline Personality Disorder. There are many people with other serious mental illnesses who experience significant functional limitations due to the symptoms of the mental illness who could benefit from case management. Also, there was discussion that people with serious mental illness also have high rates of co-occurring chronic health conditions (i.e. substance abuse disorders, obesity, diabetes) but may not be able to access MH-TCM. The group participants thought many of these individuals could benefit from case management service/care coordination assistance to access needed services and supports. As an example, tribal leaders want to see the option to include Post-Traumatic Stress Disorder as an eligible diagnosis. There was not a consensus among stakeholders about adding other eligibility criteria to MH-TCM primarily due to the need for additional study of other options that may be able to support these populations' needs.

Behavioral Health Homes are just one new program opportunity with changing health care models. This new service may be added to Minnesota's state Medicaid plan. For people who would be eligible for this new service, care coordination services (which is similar to case management) would be included to help recipients access needed services and supports. This service may be able to meet the needs of those who cannot be served by MH-TCM at this time. There was also consensus that the recommendations listed in Appendix F be implemented that describes admissions, continuing service, and discharge criteria from MH-TCM.

More fiscal analysis would need to be completed by DHS before moving forward with adding any additional eligibility criteria to case management services. The goal is to provide case management when a person has a functional need for the service, not simply due to a specific diagnosis.

Recommendations:

⁴³ <http://www.health.state.mn.us/divs/orhpc/pubs/profiles/mhprofile.pdf>

⁴⁴ Minnesota Rule 9505.0322 Sub. 4

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- DHS will consider developing a targeted case management type specific to children with developmental disabilities.
- DHS will consider implementing the recommendations of a previous advisory group process as reflected in Appendix F of this report related to admissions, continuing service and discharge criteria from MH-TCM. The recommendations need review and development of legislative language for consideration.
- DHS will further study the American Indian Mental Health Advisory Council recommendations that the eligibility criteria for MH-TCM be expanded to include people experiencing significant functional impairment due to Post Traumatic Stress Disorder.

X. Report recommendations

Additional recommendations specific to MH-TCM can be found in Appendix A: CMHSA Mental Health Targeted Case Management Redesign.

1. Definition: Adopt the following definition, agreed to by stakeholders in statute for the 2015 legislative session:

Case management is a service that provides a person with access to planning, referral, linkage, assessment, monitoring, coordination and advocacy in partnership with a person and their family⁴⁵.

A case manager assists with access to and navigation of social, health⁴⁶, education, vocational and other supports and services based on the person's values, strengths, goals and needs.

2. Case management activities list, agreed to by stakeholders.

- People receiving case management services will be given the definition and the list of activities they can expect to be provided by their case managers.
- DHS will require case managers to discuss their role with the person they are serving, including expectations, boundaries and activities they may perform on behalf of the person, whether in person or in their office.
- Information that is given to the recipient will:
 - Be in a standardized form from DHS
 - Be given to the person at the start of the service
 - Describe the service activities, responsibilities and role of the case manager
 - Show activities that will be done directly with the person and those that are done indirectly on their behalf to support their service plan
 - Describe the role and responsibilities of the person receiving case management
 - Include appeal rights and the process to file an appeal
 - Be provided and reviewed at least semi-annually

⁴⁵ Throughout this report, "Person" means the service recipient, parents of minor children and/or legal representative

⁴⁶ Includes physical health, mental health and substance abuse treatment

3. Standards and Outcome Measures

- DHS will use the current educational standards for case managers. DHS will also consider alternative, but comparable qualifications to assure cultural competence and accessibility of the service.
- DHS will require basic foundation training for case managers that would help case managers understand the definition and activities of their role. DHS would provide training tools to support the knowledge and skills that are needed by case managers.
- DHS will require continuing education for case managers; these requirements would be complimentary of their professional licensure or other continuing education requirements, if applicable.
- DHS will develop and require case management provider agencies to be certified or licensed, including identifying the costs for this.
- DHS will develop specific outcomes and performance measures for the service of case management.

4. Choice

- DHS will develop procedures to ensure people are provided meaningful choice of case management service provider. This includes providing them information about:
 - Provider agency mission and values
 - Geographic region of service
 - Availability of bilingual or bicultural case managers
 - Ratings, measures, provider report card, that includes information of personal service experience and satisfaction
- DHS will develop specific information about case management that should be given to the person who is inquiring about the service or when they are determined eligible for the service.
- DHS will require a semi-annual evaluation of the case management services in order to change the service plan as needed.
- DHS will continue to research and analyze what is needed to fully develop choice and identify any needed changes to the structure of case management in Minnesota. DHS will work with stakeholders to ensure these changes are made in partnership with lead agencies.
- DHS will continue to meet with county partners to discuss topics and issues identified in the MACSSA portion paper, Appendix E, as relates to reform efforts.

5. Caseload Size

- DHS will consider a tiered case management service to better address the goals of case management services, and match availability and intensity of service with the needs and goals of the person.
- Establishment of caseload sizes for clinical supervisors of MH-TCM should be further studied and future recommendations made. See Appendix A: CMHSA Mental Health Targeted Case Management Redesign for additional information.

6. Payment Rates and Payment Methods

- DHS will review the current time study methodology for TCM services and modify as needed, or establish a new rates model to reduce the range of monthly TCM rates.
- DHS will reevaluate the county role in the financing of TCM services as part of this review.
- DHS will consider any other systems being developed that may be applicable in the analysis for rate setting methodologies

7. Eligibility, Duplication and Service Gaps

- DHS will consider developing a targeted case management type specific to children with developmental disabilities.
- DHS will consider implementing the recommendations of a previous advisory group process as reflected in Appendix F of this report related to admissions, continuing service and discharge criteria from MH-TCM. The recommendations need review and development of legislative language for consideration.
- DHS will further study the American Indian Mental Health Advisory Council recommendations that the eligibility criteria for MH-TCM be expanded to include people experiencing significant functional impairment due to Post Traumatic Stress Disorder.

Conclusion

Case management is a critical service that provides coordination of and access to needed services and supports. Making changes to the system is complicated because of how it is funded. Changes need to be made incrementally so as not to disrupt services that are supporting a person's desire to remain in and be an active member of their community.

Over the next year, as DHS develops legislation for the 2015 session, we will continue to consult with stakeholders to develop implementation details. It will also be important to coordinate closely with other changes that are occurring in the system such as health care homes, health homes, affordable care organizations and other purchase of service delivery models that are being designed to coordinate and integrate services for people.

XI. Implementation language

Implementation of the recommendations in this report will require a request to the legislature for appropriations.

Legislative language with a request for appropriations will be presented to the 2015 legislature.

APPENDIX A

CMHSA Mental Health Targeted Case Management Redesign

Introduction

Children's and Adult Mental Health Targeted Case Management

This appendix is in response to Minnesota Laws 2013, Chapter 63, Section 19.
RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.

(a) By February 1, 2014, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation to:

- (1) increase opportunities for choice of case management service provider;
- (2) define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services;
- (3) provide guidance on caseload size to reduce variation across the state;
- (4) develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process;
- (5) develop reporting measures to determine outcomes for case management services to increase continuous quality improvement;
- (6) establish rates for the service of case management that are transparent and consistent for all medical assistance-paid case management;
- (7) develop information for case management recipients to make an informed choice of case management service provider; and
- (8) provide waiver case management recipients with an itemized list of case management services provided on a monthly basis.

(b) The commissioner shall consult with existing stakeholder groups which include representatives of counties, tribes, disability and senior advocacy groups including mental health stakeholders, managed care organizations, and service providers in preparing the recommendations and language for proposed legislation. The commissioner shall present findings, recommendations, and proposed legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

This appendix of this legislative report provides information about Mental Health Targeted Case Management (MH-TCM) services, stakeholder input process and input specific to MH-TCM in development of this report, and the recommendations and brief discussion of recommendations

of the Chemical and Mental Health Services Administration within the Minnesota Department of Human Services.

MH-TCM is one type of Medicaid-funded case management service in Minnesota. Targeted case management services are an optional service that may be provided under Medicaid authorized by Section 1915(g) of the Social Security Act. Case management is defined as “an activity which assists individual eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual”.

MH-TCM is also a covered service to eligible recipients in all Minnesota Health Care Programs.

Minnesota added adult and children’s MH-TCM services to its Medicaid benefit set in the early 1990’s.

Minnesota Statutes “target” two populations for receipt of MH-TCM services: children with severe emotional disturbances (SED) (MS 245.4871, subdivision 6) and adults with serious and persistent mental illness (SPMI) (MS 245.462, subdivision 20).

Based on 2010 data, there are about 10,000 recipients of children’s MH-TCM each year in MHCP’s; and about 23,000 recipients of adult MH-TCM. In Medicaid funding, there is a “local match” of 50% to the federal funding 50% match for most recipients of MH-TCM. County levy dollars pay a significant part of this local share. There is 100% federal funding for MH-TCM services to eligible recipients served by Tribe MH-TCM providers. MH-TCM services to eligible individuals in the expansion populations for Medicaid under the Affordable Care are funded currently at 100% federal funding for 3 years, and 90% federal funding thereafter.

There are over 100 providers of children’s MH-TCM services in Minnesota; and over 100 providers of adult MH-TCM services.

To assist in studying MH-TCM case management reform and making input for consideration in recommendations in this appendix to this legislative report, the Chemical and Mental Health Services Administration (CMHSA) Children’s and Adult Mental Health Divisions convened a large advisory group of stakeholders from the mental health service system. The CMHSA believes that it is valuable to have a board representation of the stakeholders provide input concerning any potential significant reform of a core public mental health services, such as MH-TCM.

The advisory group included representatives of family members, advocates, Minnesota Association of County Social Services Administrators representatives and other interested county staff participants, contracted private providers of MH-TCM services (both children’s and adult services providers) including providers serving minority communities, State of Minnesota Mental Health Advisory Council and its Children’s Subcommittee, the Minnesota American Indian Mental Health Advisory Council, Minnesota Department of Health, DHS Health Care and Continuing Care Administrations, a social work professional coalition, DHS Alcohol and Drug Abuse Division, and others. Membership of the Mental Health Case Management Reform Advisory Group (MH-TCM Advisory Group) is listed in Appendix D.

In July of 2013, CMHSA convened the MH-TCM Advisory Group for 9 meetings over 6 months addressing the major areas identified in the legislation. Typically about 35+ people attended each meeting in person and or teleconference. In addition, there were 6 meetings of a subcommittee of the MH-TCM Advisory Group that assisted CMHSA staff in verifying and consolidating the Advisory Group input. The group's work was advisory and provided significant information and guidance on considerations and recommendations included in this legislative report.

The MH-TCM Advisory Group had several presentations made to it including:

- Jessica Olson, State Program Administrator with DHS Disability Services Division. Jessica's presentation focused on the 2012 legislation work required of DHS with leadership by the Disability Services Division in case management reform to develop recommendations to make changes in all Medicaid paid case management services. She also discussed the next steps for 2013.
- Richard Seurer, Adult Mental Health Division with the Chemical and Mental Health Administration. Richard presented on the different case management and health care coordination models found around the country. Richard prepared a document that focused on educating the group on models.
- Cary Zahrbock, Director, Quality Improvement and Community Initiatives, Medica Behavioral Health. Cary presented on a tiered system in regards to MH-TCM service intensity and rate methodology used by Medica. This tiered system pays counties and contracted providers for the amount of time working with and on the behalf of the recipient and the recipient's parents, and is utilized in Medica's continuous improvement efforts.
- Three MH-TCM case managers Ashley Stevens of Dakota County MH-TCM services, Jocelyn Oppong of P.O.R. Emotional Wellness, and Kimberly Marette of Mental Health Resources presented on the day-to-day realities of being a MH-TCM case manager, standards of case management services, and the roles and responsibilities of their work. This enabled the advisory group to understand the world of a case manager.
- Matt Burdick, grassroots coordinator of National Alliance of Mental Illness-Minnesota (NAMI-MN), an advocacy group. Matt discussed the survey administered by NAMI-MN to gather information from current or previous recipients and their parents of case management services and their experience and input for continuous improvement.
- DiAnn Robinson, supervisor of Time Studies and Rates Unit within MN-DHS Financial Operations Division. DiAnn presented on the current rate methodology of counties and the social services time study. She gave an overview of the MH-TCM rate setting cost-based methodology which has been approved by Centers for Medicare and Medicaid Services (CMS) as part of Minnesota's state plan.
- Brad Vold, Stacy Hennen, and Pat McEvoy of the Minnesota Association of County Social Services Administrators representatives on the MH-TCM Advisory Group presented on the association's perspective on choice of providers, quality assurance, rates reform, current county levy funding of MH-TCM services, and integration/coordination of county MH-TCM services with other county services and community resources.

In addition to the MH-TCM Advisory Group, CMHSA staff met with several other stakeholder groups including individuals who experience serious mental illnesses and/or severe emotional disturbance and their families.

A. Minnesota State Advisory Council on Mental Health

DHS/CMHSA staff presented to the Minnesota State Advisory Council Children's sub-committee of Mental Health and DSD an overview of case management reform legislation. The Children's sub-committee is also represented on the mental health advisory work group.

B. American Indian Tribes

DHS/CMHSA staff presented to the Tribal Health Directors; and twice met with the Minnesota American Indian Mental Health Advisory Council - once at Grand Portage and once by teleconference to discuss case management reform and to obtain input.

Angie Hirsch, CMHSA liaison to tribes concerning mental health services led a focus group with Tribal leaders to obtain their perspective on case management and to hear their needs and ideas concerning the mental health needs of their members.

C. Counties

The Minnesota Association of County Social Service Administrators (MACSSA) appointed 3 county representatives to serve on the Mental Health Advisory sub-committee work group. An additional 4 counties participated out of the Metro County Supervisors Group. The MACSSA representatives presented to the advisory work group on the County's role in mental health case management. DHS/CMHSA staff presented to the MACSSA children's services committee.

D. Managed Care Organizations

DHS/CMHSA staff met with members of the Minnesota Council of Health Plans during their behavioral health meeting with DHS. Staff also received feedback from county-based purchasing MCOs and health plans at the quarterly coordination meeting.

E. Providers

Providers are represented on the Mental Health Advisory work groups described above. DHS/CMHSA staff has participated in contracted vendor meetings and statewide meetings informing contracted vendors of case management reform, distributing information and receiving vendor input on case management.

F. Rule 79 training for case managers

New case managers that attended the Rule 79 training of the summer and fall of 2013 were informed of the case management reform. The case managers gave input, ideas and comments on the roles and responsibilities of a case manager.

Legislative Report Topics

Children's and Adult Mental Health Targeted Case Management

What follows are background, stakeholder discussion and input, and the CMHSA recommendations specific to each of the eight topics listed in Minnesota Laws 2013, Chapter 63, Section 19. Recommendations for Further Case Management Redesign for inclusion in the legislative report. A ninth topic concerning eligibility and continuing eligibility for MH-TCM services has been included in this report.

I. Increase opportunities for choice of case management service provider

Background:

For children's and adult Mental Health Targeted Case Management (MH-TCM) there are four types of MH-TCM provider agencies:

1. In fee-for-services (FFS) model, a County-run provider agency enrolled in the Minnesota Health Care Programs (MHCP) as a recognized provider (245.4711);
2. In (FFS) model, a County-contracted provider agency enrolled in the MHCP as a recognized provider (245.4711);
3. In (FFS), a Tribe-run provider agency enrolled in the MHCP as a recognized provider; or
4. In pre-paid managed care model, a managed care organization (MCO)-contracted provider meeting Minnesota provider standards.

In the FFS model, as the "local mental health authority", counties must assure the availability of MH-TCM services to eligible county residents. The county can directly provide with its own staff and/or contract for MH-TCM services.

In the FFS model, the private MH-TCM provider agency must have a contract with each county whose residents (except tribal members if the agency has a contract with a tribe) that provider agency targets to serve.

In the "pre-paid managed care" model of service delivery, the MH-TCM provider agency must have a contract (or formal agreement) with the managed care organization (MCO) (health plan or county-based purchasing organization) to provide MH-TCM services to eligible enrollees of the MCO.

Most counties have more than one provider of MH-TCM services in the fee-for services model. However, a county in its role as the local mental health authority may limit availability of MH-TCM services to a single provider. This is often the county with its own staff.

Currently, no MCO provides MH-TCM services with MCO staff; MCO's contract with qualified MH-TCM Providers (counties and/or Tribes and/or private provider agencies). In the managed care model, MCOs must assure that there is adequate access for eligible enrollees to covered

services, including MH-TCM services. A MCO may limit the number of mental health case management provider agencies within a county to a single provider agency.

Stakeholder discussion and input:

There was discussion in the MH-TM Reform Advisory Group that there are several counties with a single provider of FFS and/or managed care children's or adult MH-TCM services. Although seen as a limitation on consumer choice, one common explanation given is that in a small population county there may be insufficient number of eligible individuals to financially justify and/or support multiple case managers, much less, multiple provider agencies.

In discussion, it was noted that MH-TCM services, as well as other mental health services have evolved to being health services and covered in Minnesota Health Care Programs; and that it is highly unusual for health services recipients to be restricted to a single provider of a Medicaid health service. The same discussion noted that it is uncommon for a county to be financial responsible for a Medicaid health service.

Discussion included comment that some potential recipients/recipients of case management services may not want to receive case management services from a county because the county is a government agency or because of past experiences with other county services or county roles.

Dr. Bravada Akinsanya of the African American Child Wellness Institute discussed ensuring that parents and children of color are included in the input process; and that DHS be aware of institutional barriers that are currently formed that impact access to and cultural competence of services.

County members noted, and representatives of the MACSSA presented at a meeting, that generally when the county is the provider of MH-TCM services there is better integration and coordination with other county social services and programs.

It is particularly relevant under the topic of "choice" and in the topic area of this report concerning "rates" to note the important role that counties perform in the provision of case management services, the contracting for and coordination with case management providers, monitoring and assuring quality, and the funding of case management services – particularly, MH-TCM services in fee-for-services.

The Minnesota Association of County Social Services Administrators has developed a 2014 "Position Statement: County's Role in Case Management". This position statement is attached as Appendix E. The county association identifies several valid issues/topics that need consideration and further discussion if changes in consumer choice and the county's role in case management services are potentially changing. The issues/topics include:

- A. Private Pay and Uninsured Clients
- B. "Administrative" or "Gatekeeper" Case Management versus "Service" or "Ongoing" Case Management
- C. Case Management versus Care Coordination
- D. Funding Mechanisms

- E. “Cherry-picking”
- F. “Audits/Program Reviews – What Have We Learned
- G. Added Responsibilities
- H. Child Welfare and Vulnerable Adult Targeted Case Management

There are millions of county levy dollars currently funding MH-TCM as well as related services. An expressed concern about potential reforms as stated by county representatives is that more children will come into the child protections system, when the child is better served by children’s MH-TCM.

Also, there was an expressed concern that “the approach to this process (used to develop this legislative report and obtain stakeholder input” has not been strength based regarding what counties are currently doing well and how to enhance that”.

There was consensus in the MH-TCM Reform Advisory Group that to support “informed choice” by recipients and parents that the provision, during the eligibility/intake process and annually thereafter, of an “orientation session” as to what case management services are, limitations, responsibilities, choice of providers, appeal rights is reasonable and doable. DHS should develop standard printed orientation materials explaining the definition of services, common questions and answers, recipient rights and responsibilities, the appeals process, choice of provider, and other information for distribution to all applicants and recipients as part of the intake process and annual review.

The advisory group agreed on the principle that a recipient should have the opportunity to choose a case management service provider and/or individual case manager. It is understood by the advisory group that this choice may result in a waiting period and/or a temporary assignment of a case manager if the recipient’s chosen case manager has a full caseload.

Concerning recipients and parents requesting to change case managers, it was noted that this is a common practice to support this choice without the individual/parents having to justify the request for a change. If there are unique circumstances of overuse of this choice, it can be dealt with individually.

CMHSA recommendations with brief discussion:

- 1) In fee-for-services and in managed care models of case management services, there should be choice given to recipients eligible for MH-TCM of provider agencies of these services in each county. Further discussion with stakeholders and counties, in particular, as to how to achieve and fund choice, and to address issues raised in the MACSSA position paper is needed.

Discussion: The current model of choice and funding is complex; solutions will take partnership and creativity.

- 2) The MH-TCM recipient/recipient’s parents should be able to request a specific individual case manager with a provider agency. The recipient/recipient’s parents need to realize that an individual case manager may not be available due to a full caseload or other reasons.

This may result in the recipient/recipient's parents having to wait for case management services or receive case management services from a case manager who is "temporarily" assigned.

Discussion: Again, as a health service, the recipient should have stronger voice as to whom they want to receive services from.

- 3) As part of the eligibility/intake determination process, applicants for case management services should receive an "orientation session" to what case management services are, limitations, responsibilities, choice of providers, appeal rights. Recipients/recipient's parents should receive at least annually, a "review orientation session" from the case management provider.

Discussion: There was consensus that this is reasonable and doable.

- 4) A recipient/recipient's parents should be able to switch case managers at least once without having to offer explanation or justification.

Discussion: This is a common practice and the large majority of the Advisory Group thought it reasonable and doable to implement as a statewide standard.

II. Define the service of case management to include the identification of roles and activities of a case manager to avoid duplication of services:

Background:

As noted in the body of this legislative report concerning case management definition, services, and roles and activities of case manager, there are common elements to definitions of all types of case management services and common components to all types of case management services. Case management is commonly defined, with some variation of language from one definition to the next, as "activity which assists individual in gaining and coordinating access to necessary care and services appropriate to the needs of an individual". Common components of reimbursable case management services (including MH-TCM) include:

1. Assessment,
2. Development of a plan,
3. Referral and linkage, and
4. Coordination and monitoring.

Other important components of case management services are the working relationship between the individual and the case manager; and the case manager's role as an advocate for the client.

Elements of assessment that may be more specific to MH-TCM may/should include:

- Review of diagnostic assessments

- Screenings using standardized tools to help determine if referral for follow up in-depth assessment by a specialist is needed. In general, screening is the brief process using interviews and/or questionnaires/survey tools to determine:
 - If an individual has indicators that might suggest a need, health problem, and/or condition (example: screening for substance abuse); or
 - If there are indicators of safety, vulnerability, or injury risk.
- Functional assessment of the recipient's skills or limitations in daily living/life skills domains, and personal risk/safety domains.
- Cultural influences and preferences of the recipient that will improve the recipient's success in accomplishing goals, and should be considered in service planning. Cultural influences mean historical, geographical, social and familial factors that affect assessment and intervention processes.
- Assessing the recipient's access to preventative and routine health care, access to continuous treatment for chronic health conditions, and health lifestyle.
- Level of Care Assessment which is used to determine the resources and resource intensity needs of the recipient's services, and are a key eligibility requirement for some services.

Stakeholder discussion and input:

The MH-TCM Reform Advisory Group discussed and supported the expansion of the definition of qualifying case management services to include assessment of, and teaching of “self-case management skills” to recipients and family. Acquiring these skills will support recipients (and parents and members of their informal support system) in becoming their own case manager and more self-sufficient in navigating health and humans services and community resources systems. Currently, the federal Center for Medicare and Medicaid Services defines targeted case management as a “broker” services and limits “skills training” by case managers.

The advisory group was very impressed and appreciative of the professionalism and dedication of the three case managers who presented about their job responsibilities and day-to-day realities of the work of mental health targeted case managers. The case manager noted the important of having reasonable caseload sizes to assure that case managers are not just responding to client urgent needs and “crises”.

The American Indian Mental Health Advisory Council recommended the updating of statute and rule to recognize tribes and tribal authority in the provision of MH-TCM services.

At Rule 79 training was held in the summer and fall of 2013 case managers were informed of the case management reform. The case managers gave input, ideas and comments on the roles and responsibilities of a case manager. They stressed the importance of obtaining the feedback of the case managers. Case Managers are the linkage to working with clients and or families. Case managers' roles and responsibilities are critical to the delivery of effect services. Case Managers have informed DHS that the case management redesign will affect them directly, and more opportunities of input should be drawn.

CMHSA recommendations with brief discussion:

- 1) Support for a common basic set of defined roles and activities of all case management services; with specific roles and activities defined as needed for specific types of case management services and/or to serve the needs of specific recipient populations.

Discussion: Common definitions should increase: understanding of what case management is; consistency of core training of all case managers; and somewhat reduce redundancy in service provision.

- 2) If possible, expand definition of qualifying case management services to include assessment of, and teaching of “self-case management/navigation skills” to recipients and family to support recipients in becoming their own case manager and more self-sufficient.

Discussion: If an overarching goal is to support recipient self-sufficiency and empowerment when possible, recipients and their families/support systems should be supported in acquiring the skills they need to be their own case managers. Currently, CMS’ model of targeted case management may not permit case managers to provide skills instruction to recipient.

- 3) MH-TCM statute is in need of general updating of language and to reflect more clearly significant changes (example: MH-TCM being a covered benefit in MHCP) and to address gaps in current language (example: role of tribal authority as relates to MH-TCM)

- 4) Further study needed to address duplication of services.

III. Eligibility: (Note: this is an additional topic added to this legislative report)

Background:

“Targeted populations” for Medicaid-funded Mental Health Targeted Case Management are children with severe emotional disturbances (SED) (Minnesota Statutes 245.4871 Subd 6) and adults with serious and persistent mental illness (SPMI) (Minnesota Statutes 245.462 Subd. 20). These Statutory definitions have been amended in previous years to somewhat expand eligibility, to reflect addition of utilization of new intensive community mental health services as eligibility criteria, to clarify statutory language as to time-linked service eligibility criteria, and to address adolescent transition into adult mental health service system.

Stakeholder discussion and input:

In the Mental Health Targeted Case Management Reform Advisory Group, there were discussions that many consumers don’t have the “right diagnoses” to meet the current SPMI and SED criteria. However, many individuals with serious mental illnesses/emotional disturbances and co-occurring chronic health conditions (such as: substance abuse disorders, obesity, diabetes,

respiratory illnesses and heart conditions) experience significant functional limitations due their mental illness/emotional disturbances just like people who currently qualify for MH-TCM. The advisory group thought many of these individuals could benefit from case management service/care coordination assistance in accessing needed services and supports.

There was not consensus in the MH-TCM Reform Advisory Group as to changes/expansion in eligibility of targeted populations of people SED or SPMI. Some members of the group thought that more study should be completed by DHS as to if individuals' case management/care coordination needs would be better addressed through alternative models of care coordination and service integration, such as current DHS planning for implementation of "Behavioral Health Homes".

The American Indian Mental Health Advisory Council did recommend that the eligibility criteria for MH-TCM be expanded to include individuals experiencing significant functional impairment due to Post Traumatic Stress Disorders (PTSD)

There was distribution and discussion of the draft 2011 summary report of the work and recommendations made by a previous advisory workgroup that helped the CMHSA look at eligibility for MH-TCM with a specific focus on admission criteria and process, continuing eligibility, and discharge criteria for MH-TCM. There were numerous references made to this previous group's work, and the MH-TCM Reform Advisory Group had some members who had served on the previous advisory group. The large majority of the Mental Health Targeted Case Management Reform Advisory Group recommended that DHS implement the recommendations of this previous workgroup.

Although quite long, this draft summary report is attached in Appendix F.

CMHSA recommendations with brief discussion:

- 1) Specific to changes or expansion of eligibility for MH-TCM should be studied further, in part, as to how MH-TCM services will fit into the larger health care reform occurring in the State, and because of recent significant changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Discussion: Better care coordination and integration of mental health and primary care services are being planned by DHS under the Medicaid State option for "health homes" in Section 2703 of the Affordable Care. Depending, in part, on the final eligibility criteria (target population) and related costs for implementation of the health home model, many more individuals experiencing SMI or SED will have access to care coordination/case management than currently are eligible for MH-TCM. Expansion of eligibility for MH-TCM should also be considered for individuals with significant functional impairment due to their serious mental illness, yet were the specific mental illness is not a qualifying diagnosis for MH-TCM services.

- 2) Review and adapt recommendations of the previous MH-TCM workgroup on "admissions, continuing stay, discharge" criteria. (See Appendix F)

These recommendations include:

- A) More specific, complete and clear eligibility criteria for MH-TCM,
- B) Linking eligibility for continuing case management services more clearly to “need” for case management services by the recipient; clarify that these services are not a “lifelong” entitlement; rather based on need for assistance in accessing needed resources/services;
- C) Expand “presumptive eligibility” criteria to address urgent needs of applicants for MH-TCM. Presumptive eligibility is the concept that if the applicant for MH-TCM appears to be eligible and has presenting urgent needs then MH-TCM services should begin so that the urgent needs can be addressed. The eligibility determination process can proceed, but reimbursement for services will only occur if and when eligibility is determined;
- D) Include exploration of CMS approval and reimbursement for MH-TCM services to assess and teach “self-case management skills” of the recipient/parents/informal support system to promote self-sufficiency and empowerment.
- E) Include “expedited readmission” in discharge criteria to support discharge planning with recipients and parents; and
- F) Include a longer “youth/young adult transition” phase for dual case management (children and adult TCM) to better insure young adults access to continuing mental health services.

Discussion: The work of the previous advisory workgroup has been endorsed by a second advisory process; and remains relevant.

IV. Guidance on caseload size to reduce variation across the State

Background:

The DHS Chemical and Mental Health Services Administration believes, and studies on mental health case management services caseload size (Rapp, C.A. & Goscha, R.J. The Strengths Model: Case Management with People with Psychiatric Disabilities. Oxford University Press, 2006. Pp 227-228) supports that establishment of reasonable caseload limits for case managers is one of the best tools to assure quality of case management services.

Current MH-TCM Administrative Rule 9520.0903 Subp. 2B. established that beginning January 1, 1994, the average caseload of a case manager providing case management services to children with severe emotional disturbance shall not exceed the ratio of 15 clients to one full-time equivalent case manager and the average caseload of a case manager providing case management services to adults with serious and persistent mental illness shall not exceed the ratio of 30 clients to one full-time equivalent case manager. The county-administered MH-TCM caseloads standard is tied to increased service revenue to support the case manager staff costs. This rule

now applies to county providers, tribal providers, contracted providers, and MCO-managed MH-TCM services.

By implementing this rule in partnership with counties over a period of three years back in the early 1990's, the average statewide caseload size of adult mental health case managers was reduced from 49 clients per one full-time equivalent case manager to 30-to-1. Adult MH-TCM caseloads sizes have been maintained at this average since then, including the current 29 clients to one full-time equivalent case manager (based on 2011 survey of caseload sizes). This reduction over time and current stability of statewide average caseload size has also been achieved with children's MH-TCM. However, there are outlier children's and adult MH-TCM providers whom DHS staff must intervene with to assure compliance with these standards.

A related topic is that MH-TCM statute (245.4871 Subd. 7) and administrative rule standards require clinical supervision of MH-TCM services by a licensed mental health professional. "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. The mental health professional must document the clinical supervision by cosigning individual treatment plans and by making entries in the client's record on supervisory activities. Clinical supervision ensures the appropriateness of assessment and the mental health services planned and provided and provides case managers and case management associates with direction and guidance on provision of services to individual clients. Clinical supervisors must meet with a case manager at least monthly.

There is no rule or standard for how many client assessments and plans, and how many case managers a clinical supervisor can reasonable be responsible for while maintaining quality MH-TCM services.

Stakeholder discussion and input:

The large majority of members of the Mental Health Targeted Case Management Reform Advisory Group supported maintenance of the current caseload size standards for children's and adult mental health case management services. More study is needed on case load size within a tiered case management service model and the resulting impact on rates and outcomes with service intensity.

In some provider agencies, clinical supervisors are supervising large numbers of functional assessments and care plans. Concern was expressed that clinical supervision of MH-TCM is not a separated funded service component of MH-TCM services, and may be underfunded in some reimbursement models. Concern was also expressed about regional shortages of licensed mental health professionals, and that some provider agencies are stretched in addressing the importance of clinical supervision for case managers and quality of services. Individual clinical supervisors have expressed concern about the number of clients that they are clinically responsible for, and feelings of being over extended. Some case managers indicated that they feel they have insufficient time with their clinical supervisors.

CMHSA recommendations with brief discussion:

- 1) Current caseload size standards for children's and adult MH-TCM should be retained.

Discussion: In general, existing caseload size standards serve recipients well as a quality standard.

- 2) If there is movement to "tiered" case management service intensity and reimbursement models, caseload size standards should be revisited and adjusted to reflect "tiering".

Discussion: Current caseload size standard as based on a case manager have an average mix of client needs for case management services. Depending on how "tiered" caseloads are designed – such as some case managers having caseloads of all clients with high needs, and other case managers having caseloads of individuals with stable situations in their lives – there may be need to adjust caseload standards to reflect the case management assistance needed by the individuals.

- 3) Establishment of caseloads sizes for clinic supervisors of children's and adult mental health case management services be further studied and future recommendations.

Discussion: for reasons noted above in Background and Stakeholder discussion, the role of clinical supervision is important to service quality, and therefore, clinical supervisors need sufficient time to fulfill this role.

V. Develop a statewide system to standardize case management provider standards, which may include establishing a licensure or certification process

Background:

Current Statute and Administrative Rule establishes standards for MH-TCM provider agencies and qualifications of individual case managers and case management associates.

In FFS, there is not a licensing or certification process for MH-TCM providers. Providers must be a county or tribe, or be contracted with by a county or tribe. In managed care model, the provider must have a contract or formal agreement with the MCO. This may involve an application process to be part of the MCOs provider network.

DHS requires MCOs to regularly audit MH-TCM provider agencies to assure compliance with MH-TCM provider agency standards, case manager qualification/continuing education standards and services standards. However in FFS, DHS does not audit MH-TCM providers in a systematic way.

Current Statute requires DHS to approve of 40 hours of training curriculums for new case managers. The Children's Mental Health Division provides this training in a classroom setting. The Adult Mental Health Division provides a web-based 5 module introduction training with optional learning assignments for new case managers.

Case managers must have continuing education training as required to maintain their qualifying individual license; or if not licensed, at least 30 hours of continuing education every two years.

Stakeholder discussion and input:

The Advisory Group discussed the need to institute a statewide system of case management provider standards and adherence; which may include establishing a licensure or certification process. The work group did not reach a consensus on whether to certify the provider entity or enroll individual case managers in MHCP. There was consensus that there needs to be more exploration on the cost and benefits of each option. The work group also had dialogue as to further research on the qualifications of case managers in reference to the impact of the Minnesota Merit System.

The American Indian Mental Health Advisory Council recommended that there be study by DHS of establishment of comparable but alternative qualifications for case managers serving members of racial minorities' communities/tribal members. There was also discussion about reimbursement for cultural consultation for non-American Indian providers serving American Indians.

CMHSA recommendations and brief discussion:

- 1) Case management provider agencies should be certified/credentialed by a process developed by DHS to assure services quality, service outcomes and outputs, provider qualifications, continued quality improvement, compliance with service standards, and for provision of technical assistance and consultation. Resources will be needed to staff the development of the certification process, the certification process, and the continued recertification process of provider agencies. The CMHS supports the development of a DHS common platform for certification/credentialing of provider agencies. The platform would realize the need for differences/additions in certification criteria specific to the type of case management and targeted population.
- 2) DHS should provide a significant portion of the common initial training, core competencies and continuing education training of case managers across types of case management; and core competencies specific to the type of case management and targeted population. Again, DHS would need the resources to develop and present the training curriculums.

Discussion: The State is looked to for the provision of best and current practices in case management services. Although many undergraduate college programs provide basic training in human services and health care, only a small portion is specific to the experience of mental illness and mental health case management services.

- 3) Further study of alternative but comparable qualifications for case managers who serve immigrant or culturally diverse populations.

Discussion: Currently, there are alternative but comparable qualifications for case managers with cultural-specific skills who serve immigrant population; and this has proven somewhat helpful in addressing the service access needs of some immigrant populations in Minnesota. However, there is a need to review these qualifications, and consider if other diverse populations might be served by case managers with specific cultural skills to address the population needs.

- 4) Further study of the role of case management associates, peer specialists, family peer specialists, community health workers, and paraprofessionals in the delivery of case management services.

Discussion: Although current statute establishes qualifications for case management associates, there are very few in the State. Increasingly on a national level and within Minnesota, mental health peer specialists are providing mental health services as part of team approaches. The value of peer specialists as part of MH-TCM services warrants study. To assure access to health care services, community health workers are increasingly being added to team efforts with some positive results. Their inclusion in provision of some MH-TCM services warrants study.

- 5) To facilitate choice and the efficient determination/redetermination of eligibility, MH-TCM provider agencies standards need to include capacity to complete diagnostic assessments in a timely fashion.

Discussion: Currently in FFS, it is regularly reported that some applicants have to wait as long as 90 days to obtain a diagnostic assessment which is a required part of the eligibility determination. Often the delay is because a diagnostic assessment is incomplete; or there is dependence on a third party diagnostician, and the diagnostician is not available or accountable to complete in a timely fashion. In managed care model, the standard reported is that diagnostic assessments are completed within 10 business days. Individuals may have urgent needs for MH-TCM services, and should have the option to choose a diagnostic assessment process that is timely. In house capacity of MH-TCM providers to do diagnostic assessments may be a partial solution.

- 6) Further study the establishment of reimburse for cultural consultation.

Discussion: There is a requirement in Children's MH-TCM that cultural consultation be done as part of the assessment and planning process; yet no reimbursement in MHCP is provided to the expert providing the cultural consultation.

VI. Develop reporting measures to determine outcomes for case management services to increase continuous quality improvement;

Background:

Currently, DHS has little evaluation information on the outcomes, outputs or quality of case management services. It is recognized that DHS needs to do more to monitor and support positive outcomes of case management services.

Stakeholder discussion and input:

Representatives of the county association communicated that they have developed a quality measurement system for some other county services (example: Child and Family Services Review system {CFRS}); and recommended that DHS study the potential of inclusion of case management services in that quality measurement system.

The MH-TCM Advisory Group agreed that there is a need to develop outcome reporting measures for case management services to increase continuous quality improvement (CQI). The work group was uniform in the desire for CQI with more study to be done on which process would be more meaningful; CQI monitoring and auditing process or the CFRS in fee-for-services provision.

The advisory group also indicated that outcome measures results of individual providers would assist recipients in choosing providers that are most effective in results and consumer satisfaction with services.

At meetings with case managers, there was some concern expressed that case managers do not have “control” over the clients’ achievement of the clients’ goals and outcomes. It was suggested that this would have to be considered in any establishment of outcomes and measures of MH-TCM services.

CMHSA recommendations and brief discussion:

- 1) Establish a minimum set of outcomes and measures common for all forms of case management that all case management providers must report on. An example of this would be tracking recipient access to routine health care – annual physical examination.
- 2) Establish an addition minimum set of outcomes and measures that are specific to each type of case management service and the population targeted. An example for adult MH-TCM is reduction in psychiatric hospitalizations/rehospitalizations.
- 3) DHS develop a provider electronic portal reporting system for case management information and measures for all providers of case management services. Funding for the development and maintenance and for additional DHS staffing would be needed to enable this system to be developed and maintained.
- 4) Further study of the quality measurement systems including the Child and Family Services Review system that the county association representatives recommended.

VII. Establish rates for the service of case management that are transparent and consistent for all medical assistance-paid case management

Background:

Targeted case management is a service defined by the federal Center for Medicare and Medicaid Services and authorized under section 1915(g) of the Social Security Act.

As such, Minnesota receives federal Medicaid (Medical Assistance) dollars for case management. The rate of federal financial participation (“federal match”) varies from State to State. In Minnesota the rate of federal financial participation is 50% federal dollars. This cost-based methodology has been approved by CMS as part of Minnesota’s State Medicaid Plan.

For children’s and adult MH-TCM, there are four types of MH-TCM provider agencies:

1. In fee-for-services (FFS) model, a County-run provider agency enrolled in the Minnesota Health Care Programs (MHCP) as a recognized provider (245.4711);
2. In (FFS) model, a County-contracted provider agency enrolled in the MHCP as a recognized provider (245.4711);
3. In (FFS), a Tribe-run provider agency enrolled in the MHCP as a recognized provider; or
4. In pre-paid managed care model, a managed care organization (MCO) -contracted provider.

There is a different rate setting method for each of these types of provider agencies:

1. In FFS, a County-run provider agency’s reimbursement is a monthly rate determined by an annual time and cost study methodology (Section 256B.094) that considers the county’s overhead costs, staff costs, caseload sizes, and a time study of case manager’s activities. Monthly rates will vary from county to county. At least one qualifying case management services must be provided to the recipient during the month.
2. In FFS, a County-contracted provider agency’s reimbursement is a monthly rate determined by the county that the contracted provider agency provides services within. The county functions as an extension of the State in determining the rate. The County-contracted provider agency must have a service contract with each of the counties that the agency provides services in. At least one qualifying case management services must be provided to the recipient during the month.
3. In FFS, a Tribe-run provider agency’s reimbursement is a Federal encounter rate for each qualifying face-to-face contact with a case management service recipient. The encounter rate is determined annually between the Federal government and the Tribe.
4. In pre-paid managed care model, the MCO- contracted provider agency’s reimbursement is a monthly rate determined by negotiations between the agency and the MCO. The agency must have a contract (or formal agreement) or recipient-specific authorization with the recipient’s MCO to provide AMH-TCM services to eligible enrollees of the MCO. At least one qualifying case management services must be provided to the recipient during the month. MCOs have the option to reimburse with “tiered” monthly rates based on the MH-TCM service intensity or recipient level of care need. . The provider agency bills and is reimbursed by the MCO; not DHS. DHS pays the MCO a capitation to manage health care services, including MH-TCM, for the enrollees of the MCO.

For MH-TCM services, is it important to note that in the fee-for-service model for county-provided and county-contracted services, counties fund the majority, but not for all MA recipients, of the “local or state match” to the “federal match”. For most MA fee-for-services, the “local match” is basically dollar for dollar match with federal funding of MH-TCM. There are subpopulations of recipients of MH-TCM services, for whom services are not eligible for federal matching funds; and or the state pays the “local match”.

MH-TCM services to eligible individuals in the expansion populations for Medicaid under the Affordable Care are funded currently at 100% federal funding for three years and 90% federal funding thereafter.

Also, counties are responsible for provision or payment for MH-TCM services for eligible individuals who are not insured or are under-insured.

Historically, the MH-TCM rate was a flat \$30/hour and the State paid the “local match”. Years ago in an agreement with the State and Counties, the Counties assumed responsibility for the “local or state” match in order to expand funding and availability of MH-TCM services, and in exchange for counties receiving millions of dollars in state grant funds. The cost-based TCM time study methodology for setting rates was federally approved. Over several years, the majority of these county grant funds have been greatly reduced and/or redirected to other purposes. Local county tax levies support a very significant portion of fee-for-services MH-TCM.

There are very significant differences in County-run monthly rates as determined by the case management time study methodology. State fiscal year 2014 monthly rates for children’s MH-TCM range from a low of \$278/month in one county to a high of \$2,626/month in another county. Over a 9-fold difference in rates. Adult MH-TCM services range from a low of \$201/month in one county to a high of \$955/month in another county. Almost a 5-fold difference in monthly rates.

FFS county-contracted provider rates are on average significantly lower; ranging from a low of \$244/month in one county to a high of \$828/month in another county for children’s MH-TCM. And for Adult MH-TCM services ranging from a low of \$203/month in one county to a high of \$849/month in another county.

For MH-TCM services provided by Tribes, funding is 100% federal dollars.

Children’s and adult MH-TCM was added to Minnesota Health Care Programs managed care contracts benefit services in 2009. Managed care organizations – both health plans and county-based purchasing organizations contract with MH-TCM providers (most counties and dozens of private providers) for provision of TCM services to eligible enrollees of the MCO. MCOs negotiate the monthly rates with these contracted providers. DHS pays a capitation add on to the MCO for managing and paying for MH-TCM services. Minnesota Statutes 256B.0625 Subd. 20 require that rates for a private contracted provider can’t be less in the managed care model than in the FFS model.

Stakeholder discussion and input:

Please see Stakeholder discussion and input above under Topic I.

The MH-TCM Advisory Group did see the value in establishment case management service rates that are transparent and based on consistent factors for all Medicaid funded case management. The work group did not reach consensus on a rate setting model, although there was uniformity that reform is needed in this area.

The Minnesota Association of County Social Services Administrators has developed a 2014 “Position Statement: County’s Role in Case Management”. This position statement is attached as Appendix E. There was discussion in the Advisory Group as to the important role that counties perform in the significant funding with local tax levies of MH-TCM services in fee-for-services.

DHS/CMHS staff has participated in contracted MH-TCM provider meetings and statewide meetings informing contracted provider of case management reform, distributing information and receiving provider input on case management. The providers gave some insight to rates being set by counties. Providers highlighted the disparities of the rates from county to county, and from county providers to county-contracted providers.

Some members of the Advisory Groups, especially private providers think that in FFS, a single methodology for rates determination should be used for County-run and County-contracted case management providers.

CMHSA recommendations and brief discussion:

- 1) The current cost and time study methodology needs to be modified significantly to reduce the considerable range of monthly TCM rates, or a new rates model established.

Discussion: There was agreement within the MH-TCM Advisory Group that the current time study methodology results in a range of monthly reimbursement rates that is not justified for the same service.

- 2) Study the recent federal Center for Medicare and Medicaid Services communication about rates setting, and prepare optional methodologies that will comply with federal expectations, and that establish more consistency of rates range.

Discussion: CMS is raising questions, not specific just to Minnesota, about cost based methodologies for health services reimbursement, and States delegating rate setting authority to other entities.

- 3) DHS should revisit with county partners the role of counties in the financing of MH-TCM services, and the topics and issues identified in the MACSSA position paper.

Discussion: Counties have been an important partner in the implementation and provision of MH-TCM services. Local county tax levies support a very significant portion of fee-for-services MH-TCM.

- 4) When a more meaningful case management outcomes and measures reporting system is established and tested, study how a portion of TCM services reimbursement might be attached to performance measurement.

Discussion: DHS has a health care reform effort that includes testing of rates reform and performance rewards.

- 5) “Tiering” of case management services and reimbursement should be studied further as an option.

Discussion: Consistent with earlier recommendation to study the option for case management services intensity being matched to recipient needs, tiered reimbursement could be supportive.

VIII. Develop information for case management recipients to make an informed choice of case management service provider

Background:

(see above Background, Stakeholder discussion and input, and CMHSA recommendations under topic III Increase opportunities for choice of case management service provider)

Stakeholder discussion and input:

(see above Background, Stakeholder discussion and input, and CMHSA recommendations under topic III Increase opportunities for choice of case management service provider)

CMHSA recommendations and brief discussion:

- 1) (see above Background, Stakeholder discussion and input, and CMHSA recommendations under topic III Increase opportunities for choice of case management service provider)

As part of the eligibility/intake determination process, applicants for case management services should receive an “orientation session” to what case management services are, limitations, responsibilities, choice of providers, appeal rights. Recipients/recipient’s parents should receive at least annually, a “review orientation session” from the case management provider.

Discussion: There was consensus that this is reasonable and doable.

IX. Provide waiver case management recipients with an itemized list of case management services provided on a monthly basis.

Background:

See body of this legislative report concerning this topic. MH-TCM services are “targeted”, not waiver case management services.

Stakeholder discussion and input:

There was limited discussion of this topic in the MH-TCM Reform Advisory Group.

CMHSA recommendations and brief discussion:

- 1) (See the recommendations in the body of this report. Further study needed to determine provision explanation of benefits recipients of MH-TCM services.

Summary Chart of Medicaid Case Management Services Minnesota Case Management Reform, 2014

| Type | Legal Authority | Target Population | Case Manager Standards | Continuing Education, Training or Supervision | Case Load Size Mandates | Eligibility | People served | Funding Information |
|---|---|---|---|--|-------------------------|--|--|---|
| Waiver Case Management: Alternative Care , Community Alternative Care , Community Alternatives for Disabled Individuals , Brain Injury , Developmental Disabilities , Elderly Waiver | Federally approved CAC, CADI, DD and BI Waiver plans, Minn. Stat. §256B.49 , Minn. Stat. §256B.092 , Minn. R. 9525.0004 to 9525.0036 , Minn. Stat. §256B.0913 | Waiver recipients for the waivers listed under type | <ul style="list-style-type: none"> •Public health nurse •Social worker: Graduate from an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or a graduate from an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency •DD Waiver: The criteria above plus one year of experience in the education/treatment of persons with developmental disabilities or related conditions | Only DD Waiver: 20 hours annually in the area of case management or developmental disability Minn. R. 9525.0012, Subp. 6 | None | <ul style="list-style-type: none"> •Each waiver program serves targeted populations. •Available to persons who choose to reside in the community and meet the eligibility criteria •Level of care is required for all waivers. This identifies the type of waiver and services available to eligible persons | SFY 2011: 4,458 people | Medicaid Waivers: 50% State Funds, 50% Federal Billed in 15 minute units |
| Rule 185 | Minn. Stat. §256B.092 , Minn. R. parts 9525.0004 to 9525.0036 | Persons w/ a developmental disability or related condition (Minn. R. part 9525.0016, Subp. 2). | The case manager must have at least a bachelor's degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with developmental disabilities, and one year of experience in the education or treatment of persons with developmental disability. | 20 hours annually in the area of case management or developmental disability Minn. R. 9525.0012, Subp. 6 | None | <ul style="list-style-type: none"> •A person must receive a comprehensive diagnostic evaluation that must indicate that the person has a diagnosis of developmental disability or a related condition •A child under the age of five years without a conclusive diagnosis must demonstrate significant sub-average intellectual function concurrent with demonstrated deficits in adaptive behavior. | Administered by counties | 100 % County funded |
| Relocation Service Coordination (RSC) | Minn. Stat. §256B.0621 , subd. 2-4 and 6-10 Federal: Title XIX, Section 1915 (g) | People residing in hospitals, nursing facilities (including certified board facilities), Intermediate Care Facilities for | • Bachelor's degree in social work, nursing, psychology, sociology or a closely related field from an accredited four-year college or university or a bachelor's degree from an accredited four-year college or university in a field other than social work, nursing, | None | None | A person must be: <ul style="list-style-type: none"> • Eligible for Medical Assistance • Reside in an eligible institution • Choose to receive RSC services to move back to the community | Duration of 180 days or less The service is limited to 32 units per day | Medicaid: 50% federal 50% state Managed Care: Capitation rate is paid per member per |

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| | | Developmental Disabilities and regional treatment centers. | psychology, sociology or a closed related field plus one year of experience in the delivery of social services to the target population as a supervised social worker in a public or private social services agency | | | | 922 people served (Fiscal Yr 2009) | month to provide services that include TCM. Capitation paid 100% by state. 15 minute units |
| Alternative Care Conversion Case Management | Minn. Stat. §256B.0913 | Adults 65 and older who are admitted to a nursing facility | <ul style="list-style-type: none"> •Public health nurse •Social worker: Graduate from an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or a graduate from an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency | None | None | A person must be: <ul style="list-style-type: none"> • Be assessed to need Nursing Facility Level of Care • Meet Alternative Care income & asset requirements • Reside in an eligible institution • Choose to receive Conversion services to move back to the community | Duration of 180 days or less | 50% State Funds, 50% Federal |
| Targeted CM for Vulnerable Adults and Developmental Disabilities (VA/DD TCM) | Minn. Stat., §256B.0924 , Minn. Stat. §626.5572 , Minn. Stat. §252A.02 , Minn. Stat. §252.27 , subd. 1a Federal: Title XIX, Section 1915g | Adults who need help to gain access to needed protective services, social, physical & mental health care, habilitative, education, vocational, recreational, advocacy, legal, chemical & others | <ul style="list-style-type: none"> •Have at least a bachelor degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with developmental disability or related conditions •Have at least one year of experience in the education or treatment of persons with developmental disabilities or a related condition | 20 hours annually in the area of case management or developmental disability Minn. R. 9525.0012, Subp. 6 | None | The person is: <ul style="list-style-type: none"> •Eighteen years of age or older •Receiving Medical Assistance •In need of service coordination to attain or maintain living in an integrated community setting •Not receiving home and community-based waiver services •Or is an adult who lacks a permanent residence and who has been without a permanent residence for at least one year or on at least four occasions in the last three years •Cannot concurrently receive waiver case management services | One face to face contact per month required FY 2011, 2,273 people utilizing services | Medicaid 50% federal 50% county |
| Mental Health Targeted CM-Children (Rule 79) | Minn. Stat., 256B.0625 , subd. 20; 245.487 to 245.4887 MN | Children with Severe Emotional Disturbance | Bachelor’s degree in one of the behavioral sciences or related fields, including but not limited to social work, psychology, or nursing from an accredited college; | •Case manager w/ 2000 hours+ supervised experience in the delivery of mental | Target Limit: 15 clients per case manager | Legally required to be provided by the county regardless of eligibility (1) the child has been admitted within the last three years or is at risk of being | Average length of service 17.1 months (2005-2009) | Medicaid 50% federal 50% county Tribal: 100 % Federal |

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| | <p>Comprehensive Children's Mental Health Act; MN Rules 8505.0332 MH CM Services; MN Rules 9520.0900 to 9520.0926 CM Services to Children</p> | | <p>or, if without a degree, must:</p> <ul style="list-style-type: none"> •Have three or four years of experience as a case manager associate; •Be an Registered Nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years | <p>health services must receive 38 hrs/yr of ongoing clinical supervision</p> <ul style="list-style-type: none"> •CM w/out 2000 hours of supervised experience in delivery of mental health services must receive: 40 hrs training approved by DHS & 1 hr/wk of clinical supervision in individual service delivery from a mental health professional until 2000 hours experience is met. •If not licensed, registered, or certified must receive 30 hrs cont ed/training in mental illness and mental health services every 2 yrs. | | <p>admitted to inpatient/residential treatment for an emotional disturbance; or (2) the child is a MN resident and is receiving inpatient treatment/residential treatment for an emotional disturbance through the interstate compact; or (3) the child has one of the following as determined by a mental health professional: (i) psychosis or a clinical depression; or (ii) risk of harming self or others as a result of an emotional disturbance; or (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or (4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.</p> | <p>44.1% continued w/ Adult MH-TCM (2010)</p> <p>59,004 children (SFY 2012)</p> | <p>County: Monthly rate</p> <p>Managed Care: Capitation rate is paid per member per month to provide services that include TCM. Capitation paid 100% by state.</p> <p>Tribe: Each face to face visit</p> |
| <p>Mental Health Targeted CM-Adult (Rule 79)</p> | <p>Minn. Stat. 256B.0625, Minn. Stat., Chapter 245, Sections 245.461 to 245.486, Minn. R., Chapter 9520, Parts 9520.0900 to 9520.0926, Minn. R.,</p> | <p>Adults with serious and persistent mental illness</p> <p>Minn. Stat., 245.462 Subdivision 20</p> <ul style="list-style-type: none"> •Typically have diagnosis of major depression, bipolar disorder, or schizophrenia | <ul style="list-style-type: none"> •Have experience & training in working with children; •Have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university •Have experience and training in identifying and assessing a wide range of children's needs; •Be knowledgeable about local | <p>Same as for Children's MH-TCM above</p> | <p>Target Limit: 30 clients per case manager</p> | <p>Meets at least one of the following criteria: (1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months; (2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;</p> | <ul style="list-style-type: none"> •Average length of service 22.4 months (2005-2009) •22,919 people (Calendar Year 2010) | <p>Medicaid 50% Federal 50% County</p> <p>Monthly rate for counties</p> <p>Managed Care: Capitation rate is paid per member per</p> |

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| | <p>Chapter 9505, Parts 9505.0010 to 9505.0140</p> | | <p>community resources and how to use those resources for the benefit of children and their families</p> | | <p>(3) the adult has been treated by a crisis team two or more times within the preceding 24 months; (4) the adult: (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; (ii) indicates a significant impairment in functioning; and (iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; (5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.</p> | | <p>month to provide services that include TCM. Capitation paid 100% by state.</p> <p>Tribal providers: Unit is paid for each face to face visit</p> |
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| <p>Child Welfare Targeted CM</p> | <p>Minn. Stat., 256B.094, subd. 1, Minn. Stat. 256F.10, Minn. Stat. 626.556 subd. 10e, Minn. R., parts 9505.2165</p> | <p>Recipients under age 21 and are at risk of maltreatment or are experiencing maltreatment or are in need of protective services</p> | <ul style="list-style-type: none"> • Hold either a bachelor's degree in: Social work, psychology, sociology, or a closely related field from an accredited four year college or university; or • A field other than social work, psychology, sociology or closely related field, plus one year of supervised experience in the delivery of social services to children as a social worker in a public or private social services agency. • Be skilled in the process of identifying and assessing a wide range of children's needs; and • Be knowledgeable about local community resources and how to use these resources for the benefits of the child; and | <p>Must complete the foundation training program developed under section 626.5591, subd. 2, must complete competency-based foundation training during their first six months of employment as a child protection worker.</p> <p>Must receive 15 hrs/yr continuing education or training relevant to providing child protective services, 626.559, Subd. 1a</p> | <p>None</p> | <p>Reimbursable for children under the age of 21 years who are enrolled in Medical Assistance (MA) or Minnesota Care and meet one of the following criteria:</p> <ol style="list-style-type: none"> 1. At risk of out of home placement or in out of home placement (Minn. Stat. 260C.212) 2. At risk of maltreatment or experiencing maltreatment 3. In need of protection or services (Minn. Stat. 260C.007, subd. 6) <p>Eligibility determination for CW-TCM services must be made by the county or tribal agency responsible for child protection services.</p> <p>Dual service eligibility A child who meets the eligibility criteria for both CW-TCM and Mental Health - Target Case Management (MH-TCM) may receive both services from the same agency and both services may be claimed in the same month as appropriate.</p> | <p>Average case open: 7 months</p> <p>3. 24,905 children served (2011)</p> | <p>Medicaid: 50% federal 50% county Tribal: 100 % Federal</p> <p>County: Monthly rate Managed Care: Capitation rate is paid per member per month to provide services that include TCM. Capitation paid 100% by state.</p> <p>Tribe: Each face to face visit</p> |
|--|--|---|--|--|--------------------|--|--|---|

MN Case Management Reform

Disability Services Division

February 2013



Minnesota Department of **Human Services**

Legislative Report

For more information contact:
Minnesota Department of Human Services
Disability Services Division
P.O. Box 64967
St. Paul, MN 55164-0967
(651) 431-2400

This information is available in alternative formats
to individuals with disabilities by calling
(651) 431-2400.

TTY users can call through Minnesota Relay at
(800) 627-3529.

For Speech-to-Speech, call
(877) 627-3848.

For additional assistance with legal rights and protections for equal access to
human services programs, contact the agency's ADA coordinator.

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I. Executive summary

The 2012 Legislature required the Minnesota Department of Human Services (DHS) to develop recommendations to make changes in all Medicaid paid case management services.

Case management is a service defined by the Centers for Medicare and Medicaid Services 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 dollars¹.

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 many reports to the legislature, including the 2011 report, [*Case management reform for persons with disabilities in Minnesota*](#)² and in the 2008 report, [*Mental Health Service Delivery and Finance Reform: Case Management Roles and Functions of Counties and Health Plans*](#)³

Recurring challenges identified in each of these reports include:

- Duplication of service
- Overlapping eligibility for programs
- Variation of rules, standards and reimbursement from program to programs
- Variation in quality and implementation from case manager to case manager

The 2011 legislative report recommended the continuation of Case Management Reform. Disability Services Division assembled two case management reform work groups. The Internal Work Group included staff from multiple divisions who are policy experts in case management. The External Work Group included representatives from various stakeholder groups, including counties, disability advocacy groups and service providers. The members addressed implementation barriers and analyzed data for all types of Medical Assistance paid case management services

The following is a summary of the work group discussion and decisions to date:

- Defined case management:

Case management is a process of assessment, planning, referral, linkage, monitoring, coordination and advocacy in partnership with a person and their family.

¹ Nonfederal share is paid either by state funds or county funds.

<https://www.revisor.leg.state.mn.us/statutes/?id=256B.0924&format=pdf>
<http://www.house.leg.state.mn.us/hrd/pubs/waiver.pdf>

² <http://archive.leg.state.mn.us/docs/2011/mandated/110488.pdf>

³ <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5346-ENG>

Minnesota Case Management Reform

A case manager assists with access to and navigation of social, health⁴, education, vocational and other supports and services based on the person's values, strengths, goals and needs.

- Defined the activities for all case management services:
 - Working relationship between the case manager and person
 - Assessment, including ongoing contact to evaluate effectiveness of support plan
 - Developing a plan of services and supports
 - Referral and Linkage
 - Monitoring and Coordination of services
 - Advocacy
- Created standards for individual case managers and case management providers
- Addressed case management eligibility, the person's need for the service, duplication and service gaps

NEXT STEPS:

While much work has been done the following activities remain to be completed:

- Choice of case manager: to increase opportunities for choice of case management service provider before the 2014 expiration of the federally approved 1915 (b) Waiver Selective Contracting Program. This federal authority has allowed Minnesota to administer case management for the waiver programs through county based health and social services programs. The goal will be to increase opportunities for choice and develop consistent provider standards with a focus on quality outcomes.
- Define and clarify the roles, activities and duplication of case management services compared to care coordination services being provide by managed care organizations. Care coordination is being implemented as part of integrated and coordinated primary care, continuing care, behavioral, and long term care services and supports.
- Improving integration of primary care, behavioral health services and long term care service and supports.
- Provide guidance on caseload size to reduce variation across the state.
- Develop a system that standardizes case management provider standards which may include establishing a licensing or certification process.
- Develop reporting measures to determine outcomes for case management services in order to drive continuous quality improvement.
- Ensure access, quality outcomes and culturally competent case management services for diverse communities

⁴ Includes physical and mental health

Minnesota Case Management Reform

- Evaluate the option to remove case management as a waiver service and redefine target populations.
- Identify populations to target and determine best approach.
- Review eligibility, continuing services, and discharge criteria
- Explore pricing for the service of case management that is transparent and consistent for all Medical Assistance paid case management.
- Identify changes need to the current reimbursement systems both at county and state level.
- Develop estimate of system modification cost and training costs.
- Analyze the impact of change on lead agencies including a cost analysis of changes to the case management system as a whole.

The department recommends continuing to work in collaboration with the stakeholders and bring an implementation plan back to the legislature in 2014.

Appendix D: MN Case Management Reform Workgroup Lists

Case Management Reform Internal Work Group

| Name | Department of Human Services Division |
|---------------------|--|
| April Beachem | Disability Services. HIV/AIDS |
| Bryan Bick | Disability Services, HIV/AIDS |
| Diane Benjamin | Disability Services |
| Karen Christensen | Alcohol and Drug Abuse Division |
| Pam Erkel | Disability Services |
| LaRone Greer | Children's Mental Health |
| Susan Krinkie | Child Safety and Permanency |
| Sue Kvendru | Purchase/Delivery Systems |
| Kate Lerner | Commissioner's Office, Policy and Operations |
| Deb Maruska | Purchase/Delivery Systems |
| Mary McGurran | Adult and Aging Services |
| Jessica Olson | Disability Services |
| Libby Rossett-Brown | Adult and Aging Services |
| Richard Seurer | Adult Mental Health |
| Shannon Smith | Disability Services |
| Jeanine Wilson | Disability Services |
| Bill Wyss | Children's Mental Health |

Case Management Reform Workgroup

| Name | Organization |
|-------------------|-------------------------------------|
| Angela Armando | Institute for Community Integration |
| Kirsten Anderson | Lutheran Social Services |
| John Wayne Barker | MnDACA |
| Elaine Carlquist | PrimeWest Health |

Appendix D: MN Case Management Reform Workgroup Lists

| | |
|-------------------|--|
| Milt Conrath | ARC Minnesota |
| Sandy DelCastillo | UCare |
| John Dinsmore | MN Association of County Social Service Administrators |
| Ed Eide | Mental Health Association of Minnesota |
| Brenda Goral | Lutheran Social Services |
| Anne Henry | Disability Law Center |
| Heidi Kammer | Resource, Inc. |
| Pete Klinkhammer | MN Brain Injury Alliance |
| Audrey Kolnes | White Earth Nation |
| Peggy Kunkel | Association of Residential Resources in Minnesota |
| Catie Lee | PrimeWest Health |
| Chrstine Lett | White Earth Nation |
| Susan McGeehan | Medica |
| Lynn Megan | MN Habilitation Coalition |
| Meghan Mohs | MN Association of County Social Service Administrators |
| Annie Napoli | MN Association of County Social Service Administrators |
| Rhonda Peterson | Association of Residential Resources in Minnesota |
| Paul Sailer | MN Association of County Social Service Administrators |
| Lori Schmidt | MN Association of Community Mental Health Providers |
| Laurie Snegosky | Local Public Health Association |
| Traci Thompson | Washington County |
| Shelly Zuzek | MN Association of Community Mental Health Providers |

Chemical and Mental Health Services Targeted Case Management Reform Advisory Workgroup

| Name | Organization |
|-------------|---------------------|
|-------------|---------------------|

Appendix D: MN Case Management Reform Workgroup Lists

| | |
|----------------------|--|
| Sue Abderholden | NAMI MN |
| Thomas Adams | African American Family Services |
| Jan Arleth | DHS, Alcohol Drug Abuse Division |
| Susan Arnston | Scott County |
| Jennifer Bartoz | White Earth Tribal Mental Health |
| Angela Bellanger | White Earth Tribal Mental Health |
| Patti Bitney-Starke | Survivor Network |
| Jennifer Blanchard | DHS, Health Care |
| Wade Brost | DHS, Adult Mental Health |
| Matt Burdick | NAMI MN |
| Karen Christensen | DHS, Alcohol Drug Abuse Division |
| Susan Dannen | Headway Emotional Health Services |
| Ed Eide | Mental Health Association of MN |
| Bonnie Freeland | MN Certification Board |
| Karen Frees | MN Social Work Coalition |
| Kathy Gregersen | Mental Health Resources |
| Linda G. Hall | Ramsey County |
| Lisa Harrison-Hadler | DHS, Regional Ombudsmen |
| Stephen Hegarty | SMHS |
| Stacy Hennen | MN Association of County Social Service Administrators |
| Stacy Jorgensen | Southwest Health and Human Services |
| Denise Kirmis | Anoka County |
| Susan Krinkie | DHS, Child Safety and Permanency |
| Catie Lee | PrimeWest Health |
| Kate Lerner | DHS, Commissioner's Office, Policy and Operations |

Appendix D: MN Case Management Reform Workgroup Lists

| | |
|------------------------|--|
| Lynn Malfeld | Hennepin County |
| Marue Maes-Voreis | Minnesota Department of Health |
| Deb Maruska | DHS, Special Needs Purchasing |
| Pat McEvoy | MN Association of County Social Service Administrators |
| Holly McIver | Tasks Unlimited |
| Ann Miller | Hammer Residences |
| Brianna Miller | African American Family Services |
| Jeanne Nelson | Center for American Indian Resources (CAIR) |
| Cheryl Lundsgaard | St. David's |
| Susan McGeehan | Medica, Behavioral Health |
| Roberta Opheim | MN DHS Ombudsmen |
| Mark Oster | Dakota County |
| Kathleen Pape | Canvas Health |
| Laurie Pumper | Mental Health Providers Association of Minnesota |
| Eric Ratzmann | MN Association of County Social Service Administrators |
| Tara Regis | HealthPartners |
| DiAnn Robinson | DHS, Financial Operation Division |
| Deborah Saxhaug | MACMH |
| Richard Seurer | DHS, Adult Mental Health |
| Patricia Sibert | Disability Law Center |
| Ben Sigrist | Tasks Unlimited |
| Melissa Simpson | P.O.R. Emotional Wellness |
| Angie Stratig | DHS, Adult and Children's Mental Health |
| Shennika Sudduth | Model Cities |
| Grace Tangjerd Schmitt | Guild Inc |

Appendix D: MN Case Management Reform Workgroup Lists

| | |
|-------------------|--|
| Connie Vandergon | South Metro Human Services |
| Brad Vold | MN Association of County Social Service Administrators |
| Antonia Wilcoxon | DHS, Commissioner's Office, Community Relations |
| Margaret Williams | Ottertail County Human Services |
| Bill Wyss | DHS, Children's Mental Health |
| Pahoua Yang | Amherst Wilder Foundation |
| Cary Zahrblock | Medica, Behavioral Health |
| Marie Zimmerman | DHS, Health Care |

Position Statement

2014

County's Role in Case Management

Short Description

| | |
|--|--|
| Issue: | There is a legislative mandate to consider choice in case management. Workgroups have been formed and counties are a partner in this process. As the State reviews case management and submits the required legislative report per the legislative requirement, it creates multiple issues for CMH-TCM as well as CW-TCM. The Counties need to establish a unified opinion on this issue going into the next legislative session and outstanding issues need to have appropriate resolution. |
| Administrative Simplification (optional): | [will this position lead to a programmatic/administrative simplification? If yes, please describe.] |
| Implementation Strategy: | <p>Counties support the issue of consumer choice in case management when the following issues are addressed:</p> <ul style="list-style-type: none">• <u>Private Pay and Uninsured Clients:</u> Will the choice for case management be the same as, or different from, those clients who are eligible for publicly-funded, i.e., MA or county levy, case management services• <u>“Administrative” or “Gatekeeper” Case Management versus “Service” or “On-going” Case Management:</u> With the advent of MNChoices assessment, will we choose to distinguish between how we designate who can provide these separate case management functions and what reimbursement will exist for each?• <u>Case Manager versus Care Coordination:</u> Do we believe that the (a) the KSA’s associated with providing these two services and (b) the activities associated with these services are separate and distinct from one another or are they interchangeable• <u>Funding Mechanisms:</u> Currently, case management type activities are funded by Medicaid dollars (waiver or TCM) and local non-federal funds (county levies). If choice is to be present for all consumers there needs to be a substitute funding for the non-federal share of TCM, a non county levy option for all case management responsibilities.• <u>“Cherry-picking”:</u> Clients’ choice must also be balanced with managing “how” and “who” providers choose to serve. Counties cannot be left only with those that have private insurance, are under insured or are hard to serve.• <u>Audits/Program Reviews - What Have We Learned:</u> Between CFSR Reviews, MA Waiver Reviews and various MCO audits, how can this info help inform us regarding our strengths and needs and how to improve our services to clients.• <u>Added responsibilities:</u> County levy dollars pay for other costs associated with clients under case management, i.e., placement cost, hold costs, other service costs. How will these costs be managed for clients who choose other providers if there is choice in case managers.• <u>CW and VA TCM:</u> Child and Adult protection are protective functions of the county and involve mitigating risk and ensuring basic safety. The county has a statutory responsibility to do that. |

Long Description:

There are a great deal of levy dollars currently attached to case management as well as a unique amount of coordinating services that are levy funded. Counties need to determine what their stance is on case management choice. The issue of what choice looks like in Greater Minnesota needs to be considered as well. The other issue to consider with CMH-TCM is that there is a great deal of coordination and crossover between CMH and CW/CP. The concern is that more children will come into the CP system when they system that would serve them better would be CMH. The other concern is that the approach to this process has not been strength based regarding what Counties currently do well and how to enhance that.

Additional Information:



Submitted by: [insert the name of the person who wrote the position]

Approved by: [insert the name of the program committee] on [insert date position was approved]

Date Approved by Legislative Committee: [insert date]

Mental Health Targeted Case Management

Admissions, Continuing Service, and Discharge Work Group

Draft Summary Report (December, 2011)

Origin: The formation of the mental health targeted case management admissions, continuing service, and discharge work group was initiated by a charge from Read Sulik, the Assistant Commissioner for the Department of Human Services' Chemical and Mental Health Services Administration at the time, to examine the quality of all programs and services managed by the administration. The admission, continuing service, and discharge criteria applied in mental health targeted case management (MH-TCM) – both Children's MH-TCM and Adult MH-TCM were considered to be a particularly worthwhile focus of such examination for several reasons including:

- 1) Ambiguity in rule and statutory language pertaining to admission, continuing service, and discharge in mental health case management had led to divergent interpretations and inconsistent practices among providers. Available length of MH-TCM services (preliminary) data highlighted the wide variability of practices and significant variance in the average length of MH-TCM services from one county to the next – suggesting that in some counties, MH-TCM is a short-term service model; and in other counties MH-TCM is a long-term multiple-year service.
- 2) Significant shifts in policy, specifically the addition of mental health targeted case management to the benefit set covered by the prepaid “managed care” Minnesota Health Care Programs (MHCP) in July 2009, have expanded the interest of health plans and county-based purchasing organizations (referred to together as “managed care organizations” – MCOs) in contributing to a common understanding and uniform enforcement of admissions, continuing service, and discharge criteria.
- 3) Increasing budgetary pressures have compelled payers to closely assess the effectiveness and efficiency of all services but especially ones as large in scope and reach as mental health targeted case management. Gaining greater clarity about the proper “dose” of mental health targeted case management service for eligible recipients and developing greater precision around how to determine readiness for discharge have the potential to increase access (e.g., reduce the number individuals receiving the service without a verifiable need so that those with pressing needs can receive timely care), improve outcomes (e.g., ensure regular monitoring of progress and appropriate adjustments to service plans), reduce liability (e.g., keeping a case “active” when the client is not being seen), save costs (e.g., avoid dedication of resources to services that are not improving client functioning or reducing symptoms), and promote service sustainability (e.g., maximize claimable encounters).
- 4) A statewide “moment-in-time” survey- July of 2010- of mental health targeted case management caseload sizes completed in the third quarter of 2010 has yielded some

indicators of service quality. These indicators have created opportunities for more in-depth exploration of critical questions related to service purpose, access, outcome measurement, and reimbursement structure.

- 5) There is a wide range of MHCP per month/per recipient unit reimbursement rates for county providers of MH-TCM services for provision of what is assumed to be the same service – mental health targeted case management. These monthly rates are also one basis for the reimbursement rates paid by MCOs to its contracted providers of MH-TCM.
 - In SFY 2012, per month per client reimbursement for county-provided child mental health targeted case management services ranges from \$335 to \$2963.
 - In SFY 2012, per month per client reimbursement for county-provided adult mental health targeted case management services ranges from \$190 to \$715.

Membership: The MH-TCM admissions, continuing service, and discharge workgroup was comprised of representatives from counties, advocacy groups, community-based providers, provider agencies, managed care organizations, and the state’s Ombudsman’s office. County representatives to the group were appointed by the Minnesota Association of County Social Service Agencies (additional county representatives attended many of the meetings). Richard Seurer from the Department of Human Services’ Adult Mental Health Division and Brownell Mack from the department’s Children’s Mental Health Division co-facilitated the group.

Process: The MH-TCM admissions, continuing service, and discharge workgroup began meeting in August 2010. Meetings were held on close to a bi-monthly schedule through June 2011. Agendas for each meeting were finalized by the DHS facilitators based on preferences and concerns identified by the group. Critical documents were sent to the group in advance of meetings in the interest of increasing the efficiency of meeting time. Outstate representatives were able to participate in meetings via interactive television. Once the parameters of the workgroup were defined, decisions about its priorities and direction were arrived at by consensus.

Issues Identified: After establishing the central purpose of the workgroup (e.g., to establish a common understanding and consistent application of the admissions, continuing service, and discharge criteria for mental health targeted case management statewide), a list of specific problems, questions, and concerns related to the topic was generated. The list included:

- 1) How can a client’s need for the service be separated from his/her eligibility for it?
- 2) What are the limitations of MH-TCM in Minnesota given it is a “brokering” service?
- 3) Is an “all-or-nothing” approach to case management meeting the needs of the targeted populations? If not, what other models or approaches should be implemented?
- 4) How is “significant impairment” conceptualized as relates to eligibility for and continuance of MH-TCM?

- 5) Is there a minimum/maximum length of services for MH-TCM?
- 6) How are the reimbursement rates for MH-TCM determined? Are they in line with service standards and expected outcomes? The significant range of monthly reimbursement rates for MH-TCM.
- 7) How can the approved functional status tools be best used by the case manager?
- 8) What are the indicators of “high quality” MH-TCM?
- 9) Is an expedited “re-entry/readmission” path to MH-TCM feasible?
- 10) How is MH-TCM best delivered to transition age youth?
- 11) What activities should be occurring in the “monitoring” phase of the service? What is the appropriate length of the “monitoring” phase?
- 12) How do case management and care coordination intersect or diverge? How does MH-TCM fit with the health care home initiative, and the integration of primary care and behavioral services?

Actions Taken:

Phase One:

In order to build a common understanding of the admissions, continuing service, and discharge criteria for MH-TCM, relevant language from Rule 79, the Adult Mental Health Act, and the Children’s Mental Health Act was presented to the workgroup during its initial meetings. Further clarification of the admission, continuing service, and discharge standards was attempted by contrasting them with similar standards for other services (e.g., children’s residential treatment). Although some compatibility between these standards was observed (e.g., need for alignment between the client’s diagnosis and the intervention plan; utilization of behaviorally-specific, measurable, and realistically attainable goals; determination of whether client is benefiting from the service; verification that the least restrictive level of care is being provided to the client), the workgroup noted fundamental differences between case management, an eligibility-driven service, and rehabilitation services which are beholden to the concept of medical necessity.

As a means for further exploring the nuances associated with admissions, continuing service, and discharge decisions in MH-TCM, the workgroup completed analysis of hypothetical cases (Appendix A). Discussion of the case validated the application of objective indicators (e.g., CASII results, progress toward measurable goals) and subjective judgment (e.g., estimation of client’s/family’s “self-navigation” capacity, evaluation of potentially destabilizing environmental factors, availability of alternate services, distinguishing parents’ need for case management services from child’s need) in the decision-making process. Based on the workgroup’s interest, the concept of self-navigation was discussed in-depth. The workgroup was introduced to a tool (Appendix B) that can be used to assess self-navigation capacity. Explanation of the SMART goal writing format (e.g., specific, measurable, agreed-upon, realistic, and time-dated) was also provided (Appendix C).

Phase Two:

Over ensuing meetings, small group discussions were led to focus attention on emerging themes (e.g., service standards, eligibility, provider qualifications, and reimbursement). The service standards subgroup completed an exercise in which it rank-ordered indicators of “high-quality” case management services. The ranking were as follows:

1. Client symptom reduction and functional improvement
2. Decrease in clients’ use of high intensity services (e.g., emergency room visits, hospitalizations, out-of-home placements)
3. Clients gaining “self-navigation” skills and Evidence of attention to mental health and physical health care needs (tie)
4. Relatively small time gap between service request and service initiation
5. Client satisfaction with services
6. Number of linkages made to non-case management services

Indicators suggested to the subgroup that did not receive votes included:

- Two or more face-to-face contacts per month.
- Relatively low caseload sizes.
- Number of case management staff who exceed minimum hiring qualifications.
- Relatively low return-to-service rates (e.g., number of discharged clients who make a new request within one year).
- Total number of case management clients served by the provider agency.
- Percentage of clients adopting healthy lifestyle practices (e.g., adequate sleep, exercise, and eating).
- Case managers receiving individual supervision from a mental health professional at least twice per month.

The service standards subgroup responded to the following question – “If MH-TCM should be broader than a “brokering” model of care (e.g., one aimed almost exclusively toward connecting clients to needed services), what are the critical, ongoing support/other activities that case managers should carry out?” – in order to clarify an appropriate scope for the service. Responses included:

- We should follow the letter of a brokering model but understand that because clients are disenfranchised, energy needs to be directed toward building trust with them.

- Even though MH-TCM doesn't allow for coaching, teaching, and other forms of direct service, case managers need to appreciate the need to build relationships and motivate clients to achieve goals.
- Being a client's "security blanket" is not an adequate reason to continue services.
- You need to be clear up front that case management is a short-term service.
- There's enough latitude in the case management rules and statutes to allow case managers to "do what they need to do."
- Examination of case histories shows that certain types of support services are needed to make case management work. We should look at examples of how to successfully move people off case management.
- It feels risky to push on CMS regarding an "enhanced" approach to case management.
- We need to legitimize the case manager's role as a change agent. They need training in approaches like motivational interviewing.

The questions "What are the unique training needs of case managers who serve transition age youth (ages 18-21)? What are the key components of effective case management services for transition age youth?" were posed to the subgroup for the purpose of defining the unique case management needs of the transition age youth population. Responses included:

- It's critical to find a person who knows the child and adult systems, which is hard to do.
- The worker needs to be aware of housing and employment issues and know how to navigate the public education system.
- The worker needs knowledge of Fostering Connections legislation.
- The case manager needs to be plugged into the county system in order to access programs and services in a timely way.
- The system should begin tracking transition age youth by age 15.
- Active mental health collaboratives are a necessary component of serving this population well.
- Overlapping child and adult workers is essential but there are reimbursement hurdles (e.g., only one gets paid). Note: The subgroup committed to developing a proposal for "transition case management" based on its concerns about transition age youth being underserved by the current case management system (Appendix D). The proposal represents a preliminary justification for a "statewide transition age payment to support the seamless and successful transition of youth from the child/adolescent MH-TCM system to the adult MH-TCM system." It calls primarily for supporting two case management workers, one from the adult system and one from the child system, to work with the youth and family for a 3-month period during which specific transition activities would be the focus of service.

Phase Three:

Most of the workgroup's later meetings were aimed at finalizing agreed-upon criteria for mental health targeted case management admissions, continuing service, and discharge – Children's MH-TCM criteria (Appendix E) and Adult MH-TCM criteria (Appendix F). In addition to reinforcing existing rule and statute language around MH-TCM admissions, continuing service, and discharge, the criteria document clarifies previously ambiguous standards and underscores best practices. Highlights of the document include:

1. Explication of appropriate use of the Diagnostic Verification Form.
2. Confirmation that case management services provided during a period of presumptive eligibility should be delivered in accordance with all applicable requirements and standards.
3. Adding supplemental indicators of instability to the SED and SPMI eligibility criteria.
4. Adding considerations for unstable situations in the individual's/family life; and for individual's/parents'/support system to acquire self-case management skills.
5. Establishing a period not to exceed 6 months for case management services focused exclusively on monitoring.
6. Allowing clients to resume MH-TCM services without a re-determination of eligibility if a return is requested within 180 days of discharge.
7. Emphasizing monthly face-to-face with the child as an ideal practice and monthly face-to-face with only the child's parent or legal guardian as an acceptable but not a preferred alternative.

Recommendations:

It was recognized at the outset of the workgroup that mental health targeted case management policy questions and concerns extending beyond the admissions, continuing service, and discharge criteria might emerge. Agreement was made to identify these issues and convey them to the Chemical and Mental Health Services Administration's leadership for further consideration, thereby providing a basis for pursuing policy and/or legislative changes. The workgroup submitted the following recommendations for future consideration:

1. Creating a data system, or improving the capacity of existing systems, to help case managers know when clients' Medical Assistance/Minnesota Health Care Program eligibility is lapsing. Workgroup members observed that the move to month-to-month determination of Medical Assistance eligibility from the previous 12-month cycle of determination has created numerous inefficiencies and repeatedly compromised quality of care through unnecessary service disruption.
2. Explore various models of case management services based on complexity of need, intensity of need – “step-down”, “step-up”, advantages of interdisciplinary team, settings for services (health clinics, consumer centers), integration with care coordination of

primary care services, “step-across” transition age (e.g., from child to adult) case management services. Telephonic/telehealth case management and certain types of care coordination may be viable alternatives to mental health targeted case management that could be added to the comprehensive benefit set. Having access to alternative models of case management would likely increase access and improve outcomes system-wide. The current “all-or-nothing” model of case management in Minnesota often pressures clients and providers to keep cases open longer than necessary. In part, reimbursement should be tied to “level-of-care” needed by recipient and/or intensity/amount of MH-TCM services provided.

3. Refine and clarify the functional assessment process. The distinctions between functional assessment, functional status, and level of care determination are fairly blurred in current DHS policy. Moreover, significant confusion exists regarding the case manager’s and the mental health professional’s respective roles in the functional assessment process. Case managers maintain statutory responsibility for completing the functional assessment but rely heavily on the cooperation of mental health professionals to uphold it. Case management providers struggle to compel the level of cooperation from mental health professionals necessary to facilitate eligibility, continuing service, and discharge determinations.
4. Provide guidance on the implications of the Affordable Care Act for MH-TCM. We should explore the intersections between MH-TCM and care coordination and define how MH-TCM applies to health homes and Accountable Care Organizations.
5. Assess the viability of “virtual” case management (e.g., teleconference, Skype) as a service delivery tool rather than as a substitute for face-to-face contact.
6. Re-examine the costs and benefits of linking respite care services to MH-TCM. Ample anecdotal evidence indicates that clients are insisting on keeping MH-TCM cases open in order to preserve access to respite care. (Other anecdotal examples of recipient wanting to maintain MH-TCM to be eligible for monthly bus card or access to free health club membership.)
7. Continuing services and discharge criteria for MH-TCM should be “need” driven; and less emphasis on just diagnosis and use of some certain mental health services.
8. “Current unstable situations in a client’s life should be criteria in considering continuation and discharge of MH-TCM services. This addresses individual situations where not just current functioning/stability have to be assessed, but additional factors related to unstable and potentially significantly changing situations in the individual’s life.
9. The client’s “self-case management skills/Self-Navigation Skills (see Appendix B)” should be a formal factor in assessing the continuation and discharge of MH-TCM services.
10. Continuation of MH-TCM services when the primary function of the case manager in the ICSP/IFCSP is monitoring a relatively stable plan should continue for 4 to 6 months

before service discharge should be a criteria (to be considered on an individual basis) for discharge planning.

11. “Expedited re-entry/readmission” for 6 to 12 months following the discharge of MH-TCM services should be an option to support/reassure recipients in discharge planning.
12. Although there was considerable discussion of the wide range of monthly reimbursement rates for MH-TCM and the time study methodology for determining the annual county-provided MH-TCM monthly rates, there was not a consensus among the work group members that this should be an area of reform.

Appendix A

Continuing Stay Case Scenario

Kevin is a 15-year-old boy who is diagnosed with depression. He has been receiving targeted case management services since being discharged from a residential treatment facility one year ago. Kevin's depressive symptoms have been stable over the last 6 months; he is taking his medication as prescribed and has not needed acute psychiatric services.

Recent events, specifically the incarceration of his older brother, appear to be elevating Kevin's distress. He is reporting increased feelings of hopelessness and decreased energy. At the last case review, Kevin's support team rated him at a Level 4 on the CASII, which has been the typical rating over the course of targeted case management services. It was noted during the review that Kevin's Individual Family Community Support Plan goals have essentially been met; he has been connected to the Boys and Girls Club for social and recreational programming, participated in weekly outpatient mental health therapy, and enrolled in an alternative school where he has made up several credits. Kevin feels he no longer needs case management services and has been less cooperative with the case manager's efforts to meet with him.

Although the consensus of the team is that Kevin could be discharged from case management, his mother wants the case to remain open. She is particularly concerned that his brother's incarceration -- Kevin and his brother are quite close -- will cause Kevin's depression to worsen. Kevin's mother contends that his progress has largely been due to the availability of case management support and she fears he will soon require more intensive services if case management is terminated.

Discussion Questions

1. Should this case be discharged? Provide a rationale for keeping the case open or discharging it. What additional information would be helpful in making a decision?
2. If this case is left open, should any changes be made to justify continued stay?

Appendix B

Self-Navigation Skills Assessment

The concept of “self-navigation skills” is divided into six domains. Each domain is rated on a five-point scale (0 = Needs minimal assistance, 5 = Needs significant assistance):

I. Assessment and Service Planning

0 = Client (e.g., family) does not need/or request assistance in this area

1 = Client is able to provide meaningful/relevant/accurate information regarding own mental health status. Client is able to identify, formulate, and express personal goals and objectives with minimal assistance from others. Client is able to translate these goals and objectives, with minimal direction, into concrete service needs and activities.

3 = Client needs and and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Client needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5 = Client needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Client is unable to express personal goals or objectives without assistance. Client needs and/or requests significant assistance from others to design/formulate service plan and activities.

II. Use of Community Resources

0 = Client does not need/or request assistance in this area.

1 = Client is able, when encouraged, to identify and articulate daily living needs. Client is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Client’s needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation. Client is able to utilize these resources with minimal assistance.

3 = Client needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the client may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

5 = Client is unable to identify or understand daily living needs. Client is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while

living in the community. Client needs and/or request significant assistance to access, navigate, or utilize existing community resources.

III. Informal Support Network Building

0 = Client does not need/or request assistance in this area.

1 = Client is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom the client interacts and from whom the client may gain informal support. Client is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3 = Client needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the client may gain informal support. Client needs and/or request moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5 = Client is unable to identify or interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Client has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Client needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

IV. Linking and Accessing Services

0 = Client does not need/or request assistance in this area.

1 = Client is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Client is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Client needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3 = Client needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Client may require and/or request moderate assistance, often in non-traditional ways, to access, establish, and maintain contact and services with the identified service providers.

5 = Client is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Client's identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Client needs and/or

requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

V. Monitoring of Service Delivery

0 = Client does not need/or request assistance in this area.

1 = Client is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Client is able and willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the client satisfied with the services received.

3 = Client needs and/or request moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Client needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5 = Client is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Client needs and/or requests significant assistance to communicate effectively and realistically about his/her progress and satisfaction with the service provider and/or the services delivered.

VI. Problem Resolution

0 = Client does not need/or request assistance in this area.

1 = Client needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation, and/or support services.

3 = Client is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation, and/or support services.

5 = Client needs and/or requests significant assistance to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation, and/or support services. Client is totally dependent on others to recognize and to take steps to overcome these barriers.

Appendix C

“SMART” Goal Writing

SMART is an acronym for Specific, Measurable, Agreed-Upon, Realistic, and Time-Dated. The SMART goal writing process begins by identifying a specific problem. Next, a goal statement is composed. The goal statement broadly describes the change desired by the child and family. The next step is to define objectives. Objectives are narrowly-framed, measurable, and observable indicators of change. Strategies to support realization of the goals are then listed. Lastly, a SMART goal identifies the person(s) responsible for carrying out the strategies and defines a date by which progress toward the goal will be reviewed.

Here is an example of a SMART goal:

Problem = Johnny (age 14) is hitting his mom when he is angry

Goal (broad): Johnny will remain safe at home

Objective (measurable, observable): Johnny will not hit mom in the next 30 days

Strategies: Johnny will calm himself using deep breathing exercise taught by therapist

Person(s) Responsible: Johnny, mother, therapist, and case manager

- 1) Johnny will practice breathing exercise in sessions with the therapist.
- 2) Therapist will teach mother a silent cue that will prompt Johnny to initiate the breathing exercise.
- 3) Case manager will monitor the effectiveness of the technique and share results with the therapist.

Date of review: June 30 (30 days from now)

Appendix D

Proposal to financially support unique needs of transition age youth receiving MH-TCM

Proposal: Develop a state wide transition age payment to support the seamless and successful transition of youth from the child/adolescent MH TCM system to the adult MH TCM system.

Background: Currently, one MH TCM provider is allowed to bill for MH TCM services per month. There is not a payment structure in place to support agencies in transitioning youth to adult MH TCM services. The lack of payment to the adult MH TCM provider, does not support the efforts of MH TCM providers to spend the necessary time with the young adult and family to ensure a seamless and successful transition to adult MH TCM. Anecdotally, it is recognized that if a youth does not make a strong connection to the new adult TCM worker prior to the closure of the TCM youth worker, that the youth is likely to discontinue MH TCM services and may re-enter the system when in crisis at a later point.

Supporting two case management workers from different entities to work with the youth and family for a 3 month time period focused around specific transition activities will likely increase the young adults continued engagement in TCM and be more cost effective in the long run.

Guidelines:

A). Timeline for transition services and payment: 3 months

B). Activities to be completed during this time:

1. Written transition plan completed in conjunction with the youth, family and both TCM workers.
2. The life domains addressed in the Independent Living plan, currently part of the Out of Home Placement Plan in SSIS, are to be addressed in the ICSP.
3. A minimum of 6 transition visits in which the new adult TCM worker is present with the youth.

C). Transition Rate:

1. Transition rate to be consistent across TCM providers and to be paid to the new provider agency. Rate would be monthly.
2. Adolescent TCM provider would continue to bill their contracted monthly TCM rate until the case is officially transferred to the adult TCM agency.

Cost Benefits:

1. Potential decrease in cost of inpatient hospital care, ER visits and crisis services.
2. Potential decrease in cost to social services related to homelessness and poverty.

Appendix E

Children's Mental Health Targeted Case Management (Children's MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

ADMISSIONS CRITERIA

Child: Individual under 18 years of age

SED Criteria: Individual meets definition of having a Severe Emotional Disturbance (245.4871)

Diagnostic Assessment: A diagnostic assessment completed within the last 180 days is needed to establish eligibility for children's MH-TCM. Information included in the diagnostic assessment is expected to conform to templates endorsed by DHS:

<http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5704A-ENG> (parent portion)

<http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5704B-ENG> (clinician portion)

DHS has also authorized use of a Diagnostic Verification Form:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6069B-ENG>

The main intent of the Diagnostic Verification form is to expedite the eligibility determination process for children's MH-TCM. A mental health professional can use the form to confirm a qualifying diagnosis and SED status while taking additional time to complete a full diagnostic report (e.g., one with all of the relevant historical information). The form can also be used to supplement other documents which may, in conjunction with the Diagnostic Assessment Form, satisfy eligibility requirements. Once completed, the diagnostic verification form can be sent to the MH-TCM provider to establish eligibility, thereby allowing services to be initiated. The form is not meant as a substitute for a full diagnostic assessment report. A mental health professional is expected to provide a complete diagnostic assessment to the MH-TCM provider within 30 days.

Presumptive eligibility: MH-TCM can be provided to a child for up to 4 months without a diagnostic assessment if: a) At the time of referral, the recipient refuses a diagnostic assessment for reasons related to his/her mental illness; b) The child's parent refuses to obtain a diagnostic assessment for the child; c) The case manager makes a reasonable determination of the child's eligibility (e.g., child is being discharged from an acute care setting but has yet to receive a comprehensive diagnostic assessment); d) Additional time is needed to obtain a culturally competent diagnostic assessment. During the presumptive eligibility period, it is expected that case management services will be provided in accordance with all applicable requirements and standards.

Significant Impairment: The functional assessment criteria (245.487 subd. 18) define 11 domains in which impairment should be evaluated:

- 1) Mental health symptoms as presented in the child's diagnostic assessment

- 2) Mental health needs as presented in the child's diagnostic assessment
- 3) Use of drugs and alcohol
- 4) Vocational and educational functioning
- 5) Social functioning, including the use of leisure time
- 6) Interpersonal functioning, including relationships with the child's family
- 7) Self-care and independent living capacity
- 8) Medical and dental health
- 9) Financial assistance needs
- 10) Housing and transportation needs
- 11) Other needs and problems

Clause #4 of the SED definition requires that a child demonstrate significantly impaired home, school, or community functioning that has lasted at least one year or in the written opinion of a mental health professional presents substantial risk of lasting at least one year. The following indicators of instability should be factored into a determination of significant impairment. Each indicator must have a substantial and direct impact on the mental health functioning of the child.

1. Present or recent hospitalization, residential treatment placement, or psychiatric crisis.
2. Major, multiple, or complex physical health conditions that are not adequately managed.
3. Major psychosocial changes anticipated in the next 3 months (e.g., change in parental custody; unstable housing or high mobility; deployment of parent; family relocation; change in school or educational setting). *Note that the nature of the change can be positive (e.g., transitioning to a less restrictive educational environment. The key factor is the effect of the stressor on the child or family, particularly in regard to the child's mental health problems and treatment needs.
4. Vulnerability to harm or exploitation.

Tribal Case Management: Tribal members eligible for MH-TCM can receive it through an Indian Health Service or a Tribal Health Facility. MH-TCM services provided by an Indian Health Service or Tribal Health Facility are reimbursed at the federal encounter rate. Tribal members concurrently enrolled in managed care can access MH-TCM from a provider participating in their plan. In instances where tribes operate urban satellite facilities, tribal members can access MH-TCM from these locations.

Coverage: Children's MH-TCM is a covered service under the individual's health care program or paid by the individual's county of financial responsibility if he/she is uninsured or covered by a commercial plan.

Alternative Service: If a child eligible for MH-TCM is offered an alternative service, the child and family must be given an explanation of what MH-TCM provides, how the alternative service is similar to or different from MH-TCM, and what benefits and risks are associated with the alternative service.

Level of Care: The Early Childhood Service Intensity Instrument and the Child and Adolescent Service Intensity Instrument are the measures approved by DHS for level of care determination. MH-TCM is defined by these measures as an intensive outpatient or Level 3 service.

Role of Case Manager: The role of the children's MH-TCM provider centers on the delivery of four core services: Assessment, planning, referral and linkage, and monitoring.

Children's Mental Health Targeted Case Management (Children's MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

CONTINUING SERVICES CRITERIA

Child: Individual is under 18 years of age. Planning around whether to maintain youth in the children's mental health system or transfer to the adult mental health system must be broached at least 6 months prior to child turning 18. Upon turning 18 (with no discharge from children's system), the client can continue to receive services provided by the child or adult mental health system if a mental health professional recommends continuation of services

SED Criteria: An 18-21 year-old client who remains in the children's mental health system would not be subject to the Serious and Persistent Mental Illness (SPMI) eligibility criteria used for the adult population. If the client discontinued case management services prior to age 18 and then requested case management services after age 18, the client would need to meet SPMI criteria.

Diagnostic Assessment: A diagnostic assessment must be updated at least every 36 months. When a youth who has had been receiving MH-TCM services under the SED criteria reaches age 21, the next diagnostic assessment must establish that he/she meets SPMI criteria in order for MH-TCM services to continue. A reasonable grace period for obtaining a new diagnostic assessment of a client previously determined to be eligible for MH-TCM is appropriate.

Note: When clients enroll in health plans, the agreements they sign typically entitle the health plan to information it needs to gain or seek reimbursement for services and to coordinate benefits. A diagnostic assessment on a case management client completed by a provider under contract with the health plan would be an example of such information. A provider can therefore release a diagnostic assessment to the health plan upon the health plan's request without additional consent. The client's certificate of coverage will explain the types of information "owned" by the health plan and how such information can be used. In instances where a client has switched from one health plan to another, it is advisable to obtain proper consent before "re-releasing" a diagnostic assessment to a new payer.

Tribal Case Management: For enrolled members of Minnesota tribes, the individual can choose MH-TCM services from a tribal provider, a county provider, or a Minnesota Health Care Program provider.

Coverage: Children's MH-TCM continues as a covered service in the individual's health care program or is paid by the individual's county of financial responsibility if he/she is uninsured or covered by a commercial plan.

Alternative Service: If a child eligible for MH-TCM is offered an alternative service, the child and family must be given an explanation of how the alternative service is similar to or different from MH-TCM as well as information about the benefits and risks associated with the alternative service.

Level of Care: A re-determination of the child's level of care should be completed with the ECSII or CASII within 180 days of service initiation.

Role of Case Manager: When monitoring has been the primary service provided by the case manager for at least 3 months, the need for continuing services should be evaluated. The CASII/ECSII results should support the assigned level of service.

IFCSP: The IFCSP should be reviewed at least every 180 days. DHS considers a review every 90 days to be a best practice. IFCSP goals should be written in specific and measurable terms (in order to best gauge the client's need for continuing service).

Self-Navigation Skills: The child and/or family continue to require MH-TCM services due to significant difficulties in two or more of the following domains. The navigation skill can be present within the client's support system versus being specific to the client.

1. Assessment and service planning
2. Informal support and network building
3. Use of community resources
4. Linking and accessing services
5. Monitoring of service delivery
6. Problem solving skills

Significant Impairment: In addition to impairment present in the functional domains established by Minnesota Statute 245.487 subd. 18, the following indicators of instability can be used to justify continuing services. Particular attention should be given to whether the indicator is having a substantial and direct impact on the child's mental health problems or overall functioning.

1. Present or recent hospitalization, residential treatment placement, or psychiatric crisis
2. Major, multiple, or complex physical health conditions that are not adequately managed
3. Major psychosocial changes anticipated in the next 3 months (e.g., change in parental custody; unstable housing or high mobility; deployment of parent; family relocation; change in school or educational setting). *Note that the nature of the change can be positive (e.g., transitioning to a less restrictive educational environment. The key factor is the effect of the stressor on the child or family, particularly in regard to the impact of the stressor on the child's mental health problems and treatment needs.
4. Vulnerability to harm or exploitation

Children's Mental Health Targeted Case Management (Children's MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

DISCHARGE CRITERIA

Child: Individual is no longer 18 or is not eligible to continue MH-TCM under the transition-age youth criteria.

SED Criteria: Child no longer meets SED eligibility criteria.

Transfer: Transfer of a case management client to another provider may be necessitated by the client's relocation and/or changes in the client's health care coverage. To facilitate a change in case management providers, a document called the Mental Health Targeted Case Management Universal Transfer Form can be utilized (e-docs link at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6063-ENG>)

The intent of the Universal Transfer Form is to convey up-to-date and particularly vital client information (e.g., current service needs, name of primary care provider, court involvement) from the previous case management provider to the new one. The form may also be useful as a face sheet for sending the Individual Family Community Support Plan to the new provider.

It is expected that all relevant case information be sent by the previous service provider to the new service provider within 30 days. A face-to-face meeting between the previous case manager and the new case manager is advisable during this 30-day period to promote a seamless transfer of care.

Tribal Case Management: The client has chosen MH-TCM from a different tribal provider, a county provider, or from a Minnesota Health Care Program payer.

Coverage: Children's MH-TCM is not a covered service in the client's health care program or the county of financial responsibility is unable to fund the service for the client if he/she is uninsured or covered by a commercial plan.

Alternative Service: The client is offered and accepts an alternative service to MH-TCM, assuming client has been adequately informed about what the alternative service does and does not provide.

Level of Care: ECSII/CASII results indicate that MH-TCM is not the appropriate level of care. A referral is made to a more appropriate service. The MH-TCM provider offers the child and/or family the support necessary to complete the referral if accepted.

Role of Case Manager: Discharge from services warrants strong consideration if the case manager's role has been limited to monitoring the existing IFCSP for at least the last 3 months and if the IFCSP is adequate to address the client's current goals with non-MH-TCM services or resources already in place.

IFCSP: Termination of the IFCSP is justified if:

- 1) there is mutual agreement between the case manager and the client that IFCSP goals have been met.
- 2) the client does not have major unaddressed needs/goals that he/she is willing to address.

- 3) the child and family have expressly declined to continue working toward completion of unfinished goals.
- 4) the child and family are informed that they can return to MH-TCM services within 180 days without requiring a new determination of eligibility.

Self-Navigation Skills: The child and/or family are demonstrating adequate skills in at least 5 of the following 6 domains:

1. Assessment and service planning
2. Informal support and network building
3. Use of community resources
4. Linking and accessing services
5. Monitoring of service delivery
6. Problem solving

Significant Impairment: The client has returned to a baseline level of functioning or is no longer demonstrating significant impairment in the functional domains established by Minnesota Statute 245.487 subd. 18. The client also is not presenting any of the following indicators of instability. Particular attention should be given to whether the indicator is having a substantial and direct impact on the child's mental health problems or overall functioning.

1. Present or recent hospitalization, residential treatment placement, or psychiatric crisis
2. Major, multiple, or complex physical health conditions that are not adequately managed
3. Major psychosocial changes anticipated in the next 3 months (e.g., change in parental custody; unstable housing or high mobility deployment of parent; family relocation; change in school or educational setting). *Note that the nature of the change can be positive (e.g., transitioning to a less restrictive educational environment. The key factor is the effect of the stressor on the child or family, particularly in regard to the impact of the stressor on the child's mental health problems and treatment needs.
4. Vulnerability to harm or exploitation.

No Contact: There has been no face-to-face contact between the case manager and the child for 90 consecutive days because the child or child's legal guardian has failed to keep an appointment or has refused to meet with the case manager. Although either a monthly face-to-face contact with the child or the child's legal guardian is claimable, monthly face-to-face contact with a child is considered a best practice given that it promotes comprehensive and accurate assessment.

Appendix F

Adult Mental Health Targeted Case Management (adult MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

ADMISSION CRITERIA:

- **ADULT** - Individual is age 18 or older, and
- **SPMI CRITERIA** - Individual meets definition of having a *Serious and Persistent Mental Illness* (Minnesota Statutes 245.462 Subdivision 20). This includes that the individual likely has “significant impairment of functioning”; and
- **DIAGNOSTIC ASSESSMENT** - If not currently receiving MH-TCM, the individual has not had a diagnostic assessment within the past 180 days. *Presumptive eligibility*: MH-TCM can be provided for up to 4 months without a diagnostic assessment if a) individual refuses a DA for reasons related to his/her mental illness; b) the county/tribe/MCO makes a preliminary determination that the individual is likely eligible (however, reimbursement is only provided for services to eligible individuals. Provider needs to hold billing for MH-TCM until DA completed and formal eligibility determination made); and
- **VOLUNTARY OR COMMITMENT** - Individual wants the service (voluntary); or civil committed to MH-TCM services by court process, and
- **OTHER INELIGIBILITY** - Individual is not in nursing home and/or cannot/no plan to return to the community within the next 180 days; and
- **COVERAGE** - Adult MH-TCM is a covered service in the individual’s health care program (MH-TCM is a covered service in Minnesota Health Care Programs), or is paid by individual’s county of financial responsibility (within fiscal constraints) for uninsured/uncovered; and
- **ALTERNATIVE SERVICE** - If eligible individual is offered an alternative service to adult MH-TCM, the individual chooses adult MH-TCM. (If offered an alternative services, the individual must be given an explanation of what adult MH-TCM is and the benefits of the services and how the alternative service is similar and different than MH-TCM), and
- **ROLE OF CASE MANAGER** – (Preliminary assessment) Role for case manager is identified – assessment, planning, referral and linkage, and/or monitoring and coordination; and
- **ICSP SERVICES/RESOURCES** – (Preliminary assessment) ICSP referral-type services and resources are identified, but not used; not stable, new referrals/coordination needed; and/or not working well.

Adult Mental Health Targeted Case Management (adult MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

CONTINUING SERVICES CRITERIA: (reviewed at least every 180 days)

- **ADULT** - Individual is age 18 or older, and
- **SPMI CRITERIA** - Individual meets definition of having a *Serious and Persistent Mental Illness* (Minnesota Statutes 245.462 Subdivision 20), and
- **DIAGNOSTIC ASSESSMENT** - Individual has had a diagnostic assessment within the past 3 years,
- **VOLUNTARY OR COMMITMENT** - Individual wants the service (voluntary); or civil committed to MH-TCM services by court process, and
- **INDIVIDUAL IDENTIFIES AND ADDRESSES AT LEAST ONE GOAL AREA IN ISCP;** and
- **OTHER INELIGIBILITY** – Individual is not in nursing home and/or cannot/no plan to return to the community within 180 days; and
- **COVERAGE** - Adult MH-TCM continues as a covered service in the individual’s health care program, or is paid by individual’s county of financial responsibility (within fiscal constraints) for uninsured/uncovered; and
- **ALTERNATIVE SERVICE** - If the individual is offered an alternative service to adult MH-TCM, but continues to choose MH-TCM, and
- **ROLE OF CASE MANAGER** - Role for case manager is identified – assessment, planning, referral and linkage, monitoring and coordination. Case management role involves active assessment, planning and referral and linkage to address individual goals; OR if case management role is primarily just monitoring the existing ICSP, the monitoring has been for less than 6 months; and
- **ICSP SERVICES/RESOURCES** – ICSP referral-type services and resources used are not stable, are new, or yet not working well; and
- **IMPAIRMENT/UNSTABLE SITUATION/SELF-CASE MANAGEMENT SKILLS** – Individual has at least one of the following:
 - A. **SIGNIFICANT FUNCTIONAL IMPAIRMENT** – Individual currently has at least one significant functional impairment identified in the functional assessment that the individual is interested in addressing in the ICSP, and for which there is not an ongoing lead provider/resource/support responsible for coordination;
 - B. **CURRENT UNSTABLE SITUATIONS** – Individual currently has a significantly unstable situation in at least one of the following for which there is not an ongoing lead provider/resource responsible for coordination/services:
 1. PRESENT OR RECENT HOSPITALIZATION/RESIDENTIAL TREATMENT/PSYCHIATRIC CRISIS
 2. UNSTABLE HOUSING
 3. UNSTABLE MAJOR SYMPTOMS
 4. UNSTABLE BENEFITS
 5. ACTIVE SUBSTANCE ABUSE
 6. VULNERABILITY/ RISK
 7. MAJOR OR MULTIPLE COMPLEX PHYSICAL HEALTH CONDITIONS NOT WELL MANAGED
 8. MAJOR CHANGES ANTICIPATED - in individual’s life situation anticipated within 3 months

- C. **SELF-CASE MANAGEMENT SKILLS** – Individual’s “Self-navigation/Self-case management skills” (this includes support of individual’s informal support system) is significantly inadequate in two or more of the domains of:
1. assessment and service planning,
 2. informal support and network building,
 3. use of community resources,
 4. linking and accessing services,
 5. monitoring of service delivery,
 6. and problem resolution.

Adult Mental Health Targeted Case Management (adult MH-TCM)

Admissions, Continuing Services, and Discharge Criteria (Draft 6/21/11)

DISCHARGE CRITERIA: (reviewed at least every 180 days)

- **ADULT** - Individual is not age 18 or older, or
- **SPMI CRITERIA** – Individual does not meet definition of having a *Serious and Persistent Mental Illness* (Minnesota Statutes 245.462 Subdivision 20), (Mental health professional furnishes written opinion that the individual no longer meets the eligibility criteria (client has appeal rights); or
- **DIAGNOSTIC ASSESSMENT** - Individual has not had a diagnostic assessment within the past 3 years, and refuses to participate in obtaining one; or
- **OTHER INELIGIBILITY** - Individual is in nursing home and cannot/no plan to return to the community within 180 days; or
- **TRANSFER** – Individual moves - Individual has moved to another county/MCO area (referral made for MH-TCM in new home community); or
- **VOLUNTARY OR COMMITMENT** –
 1. Individual no longer wants MH-TCM (voluntary); or
 2. Status of civil commitment to MH-TCM services by court process (site commitment act) has ended and individual does not want MH-TCM; or
 3. Individual and case manager mutually decide the individual no longer needs case management services; or
 4. Individual refuses services (unless civil commitment); or
 5. Except for an individual in residential treatment facility, regional treatment center, or acute care hospital for the treatment of a serious and persistent mental illness in a county outside the county of financial responsibility, no face-to-face contact has occurred between the case manager and the individual for 180 consecutive days because the individual has failed to keep an appointment or refused to meet with the case manager;
- **INDIVIDUAL DOES NOT IDENTIFY AND ADDRESS AT LEAST ONE GOAL AREA IN ICSP;** and
- **COVERAGE** - Adult MH-TCM is not a covered service in the individual's health care program, or county is unable to fund the service for the individual who does not have insurance/coverage; or
- **ALTERNATIVE SERVICE** – The individual is offered and accepts an alternative service to adult MH-TCM, (the individual must be given an explanation of what adult MH-TCM is and the benefits of the services and how the alternative service is similar and different than MH-TCM), or
- **ROLE OF CASE MANAGER** – The case management role is primarily just monitoring the existing ICSP. The ICSP is adequate to address individual's current goals with current non-MH-TCM services/resources/supports. Individual does not have major unaddressed needs/goals that the individual wants to address at this time. The case manager role of primarily just monitoring has been at least 6 months; or
- **ICSP SERVICES/RESOURCES** – ICSP referral-type services and resources used are stable, are not new; and are working well. Individual has been referred/linked to needed resources/services for needs/goals that individual agrees to address; or
- **IMPAIRMENT/UNSTABLE SITUATION/SELF-CASE MANAGEMENT SKILLS** – Individual does not have at least one of the following:
 - A. **SIGNIFICANT FUNCTIONAL IMPAIRMENT** – Individual currently does not have at least one significant functional impairment identified in the functional assessment that

the individual is interested in addressing in the ICSP, and for which there is not an ongoing lead provider/resource/support responsible for coordination;

- B. **CURRENT UNSTABLE SITUATIONS** – Individual currently does not have a significantly unstable situation in at least one of the following for which there is not an ongoing lead provider/resource responsible for coordination/services:
1. PRESENT OR RECENT HOSPITALIZATION/RESIDENTIAL TREATMENT/PSYCHIATRIC CRISIS
 2. UNSTABLE HOUSING
 3. UNSTABLE MAJOR SYMPTOMS
 4. UNSTABLE BENEFITS
 5. ACTIVE SUBSTANCE ABUSE
 6. VULNERABILITY/ RISK
 7. MAJOR OR MULTIPLE COMPLEX PHYSICAL HEALTH CONDITIONS NOT WELL MANAGED
 8. MAJOR CHANGES ANTICIPATED - in individual's life situation anticipated within 3 months
- C. **SELF-CASE MANAGEMENT SKILLS** – Individual's "Self-navigation/Self-case management skills" (this includes support of individual's informal support system) is not significantly inadequate in two or more of the domains of:
1. assessment and service planning,
 2. informal support and network building,
 3. use of community resources,
 4. linking and accessing services,
 5. monitoring of service delivery,
 6. and problem resolution.

Expedited Readmission: Expedited readmission is the process of prompt resumption of adult MH-TCM to a recent client of adult MH-TCM by bypassing many of the intake procedures for new referrals. Providers of Adult MH-TCM are encouraged to offer "expedited readmission" within the first year following services discharge of adult MH-TCM services to clients to whom services are ending. This may be reassuring to an individual who may not be confident that the individual can navigate the mental health and various other systems without a case manager, and/or is concerned about relapse. For adult MH-TCM services, an expedited readmission procedure/model is preferred rather than maintaining MH-TCM services long term in a largely "monitoring" model.

APPEAL RIGHTS

Individual who applies for or receives case management services has the right to a fair hearing under Minnesota Statutes, section 256.045, if the county (MCO) terminates, denies, or suspends MH-TCM services, or does not act within five days upon a request or referral for MH-TCM services. Fiscal limitations described in Minnesota Statutes, section 245.486, shall constitute a basis for the county of financial responsibility to refuse to provide or fund the services at issue in the appeal.

245.486 LIMITED APPROPRIATIONS.

Nothing in sections [245.461](#) to [245.485](#) and [245.487](#) to [245.4889](#) shall be construed to require the commissioner or county boards to fund services beyond the limits of legislative appropriations.

245.462 Definitions (SPMI)

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) The adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) The adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) The adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) The adult:

(i) have a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued;
or

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section [245.4871, subdivision 6](#); and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.