Case Management Redesign

Initial Design Team Project Charter

Revision History

| **Date** | **Version** | **Description** | **Author** |
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|  | 1.0 | First Draft | Lisa Cariveau |

# Project Name: Initial Design Team for Case Management Services

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**Executive Sponsors:** Jane Hardwick, President, MACSSA and Chuck Johnson, Deputy Commissioner, DHS

**Project Manager:** Lisa Cariveau, Community and Care Integration Reform Team, DHS

## Business Need and Opportunity

Case management is a service that is provided through Minnesota’s Medical Assistance program. It is defined in 1915(g) of the Social Security act as a service to assist eligible individuals in accessing needed medical, social, educational and other needed services.

As allowed by the Centers for Medicare and Medicaid Services (CMS), case management in Minnesota is designed and funded in different ways. One way is through targeting specific populations such as persons who have mental illnesses or developmental disabilities or for persons who receive long term services. Another way is as a service through home and community based waivers.

Over the years the case management system in Minnesota has become very complex. There is not one system for case management. We have multiple types of case management under different program. Some of the challenges this has caused 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

In 2013, the Minnesota Legislature required DHS to 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.

The 2013 report to the Legislature, [MN Case Management Reform](https://www.leg.state.mn.us/docs/2013/mandated/130475.pdf), described the effort to redesign all types of case management services (CM redesign) within multiple divisions at DHS. Significant works remains in order to implement the recommendations outlined in the report and make the system more responsive to people who need these services.

DHS, along with county and Tribal partners and external stakeholders have put considerable work into creating recommendations for redesigning case management services. This work will be a foundation for developing a uniform set of core case management services. The case management redesign initiative provides Minnesota with the opportunity to design a core set of services that meet the needs of the people, families, and communities we serve.

## Risks and Issues

The approach to this phase of case management redesign was directly informed by the identified barriers to the success of past planning efforts as well as areas of agreement about the next phase of planning. Identified barriers to the success of past planning efforts include:

1. **High stakes.** Tribes and counties are very dependent on the flow of funds for case management that is governed by the current rate-setting process. Staffing, contracts, and local taxation levels have developed around the current process.
2. **Unequal financial risk.** CM redesign is likely to create financial winners and losers, especially among counties, who pay for most case management services. The current system of rate-setting benefits urban counties that can choose to contract with providers to take their lower-intensity cases and save only the most intensive cases for county staff. Rural counties have less opportunity to take this approach because they don’t have enough high-intensity cases and there are few other providers to contract with. These differing positions can make it difficult to find solutions.
3. **Role of counties.** DHS has tended to treat the counties as if they were just another stakeholder in case management planning, rather than as their partner in a state-supervised, county-administered service system. This has been very frustrating to counties and has been seen as a lack of understanding of how the system works.
4. **Role of Tribes.** There has not been a comprehensive effort made to document the role Tribes play in the various forms of case management. Nor has there been an analysis of the implications of how changes in the case management rates and service provisions will impact Tribal services.
5. **Rate-setting complexity.** Case management rate-setting is complex enough that most participants don’t understand how it actually works, especially how it affects Tribal and county budgets. The “devil is in the details” and few people understand the details. There is concern that DHS and other stakeholders don’t understand the financial implications of the solutions they promote. There is also concern that the few people in the state who truly understand the detailed complexity (both within DHS and in Tribes and counties) are retiring and DHS will soon lose the historical perspective and technical knowledge it needs to fix case management rate-setting.
6. **Rate-setting transparence.** There has been concerned by the lack of transparency in the current TCM rate-setting process. The perceived lack of transparency contributes to mistrust and frustration during meetings.
7. **Wrong people in the room.** In past planning processes, there has been concern that the wrong people were in the room to make the decisions being considered. Most specifically participants’ understanding of the fiscal implications of decisions and lack of fiscal staff at meetings.
8. **Difficulty of designing a do-able project.** The huge scope of the case management issue has made it difficult to define do-able sub-projects and maintain momentum on those projects. Some partners and stakeholders believe DHS should start with rate-setting; others think DHS should tackle the definitions, activities and standards of case management first. Still others think DHS should stand back and ask big questions about the role of case management (as a whole) in a managed care state.
9. **Lack of “big picture” understanding.** Case management affects many aspects of health and social service provision. It has been difficult to redesign because participants often focus just on their piece of the puzzle; complexity makes it challenging to formulate an overall system view. It is important that staff assigned to the case management planning project have a clear understanding of the differing perspectives of partners and stakeholders.

## Points of agreement about the next phase of planning

1. **Build on past work**. There was clear agreement that any future planning process should start by reviewing and synthesizing previous planning work and building on that.
2. **Satisfy CMS[[1]](#footnote-1)**. There was clear agreement that if there are changes that CMS requires DHS should work towards addressing them. Some partners wanted to hear more from DHS on the state’s understanding of what CMS is requesting or requiring.
3. **Fix immediate problems where possible**. No matter what the scope of future planning, it would be worthwhile to clarify existing problems, where possible.
4. **Adopt a realistic timeline**. The next phase of planning should adopt a realistic timeline for case management planning. Past timelines have been viewed as unrealistically short and have impacted a partner and stakeholders willingness to engage in the work.
5. **Align with Olmstead planning**. Any redesign of case management should be informed by Olmstead principles.
6. **Consider other changes already being implemented**. The case management planning process must take into account the other initiatives that county social services agencies are implementing with DHS, such as System Modernization. There should be clear articulation of the overall vision of how these efforts intersect with CM redesign planning.

### Planning assumptions

The Case Management Leadership Alignment team has agreed to a set of planning assumptions to guide the work of the initial design team. The team will use the following assumptions for designing a core set of case management services. The assumptions do not represent final decisions, however, they do provide a framework for the team discussions.

* All types of Medicaid-funded case management are included in the scope of the redesign efforts. This includes case management services that have been authorized but not yet designed, including Home Care Case Management.
* We are creating a single benefit set for all MA case management services that could be offered to a broader population. This means that we would seek a single authority for all MA case management services.  This planning assumption assumes we would remove case management services from the waivers.
* The core services will have the following in common:
* Core activities
* Roles and responsibilities of service delivery
* Foundational provider qualifications
* Foundational provider training
* Ways to identify and measure common outcomes and quality
* The uniform core services will be expanded upon to reflect variation in a population’s needs and expertise needed to deliver the services.
* The uniform core services will inform the financially modeling work which will include options for paying for variations.

### Planning parameters

1. Federal requirements. The definition of case management services need to meet federal Medicaid requirements, including federal regulation regarding allowable case management activities and federal authority needed to finance case management services.
2. Timeline. Calendar year 2018 is the time to create the initial design for case management services. The initial design team needs to create an initial model by September 2018 in order to vet and refine the model in the remainder of 2018 into early 2019. We have a plan to submit a proposal for statutory language for the 2020 legislative session, with a plan to begin implementing changes in 2021.

## Scope

In order to ensure that our conversations are productive and move towards a collective goal, we need to identify what is within scope and out of scope for the initial design team.

### In scope

* The scope of the case management redesign initiative will include:
	+ Waivered case management, including:
		- Community Alternative Care (CAC)
		- Community Access for Disability Inclusion (CADI)
		- Developmental Disabilities Waiver (DD)
		- Elderly Waiver (EW)
		- Brain Injury (BI)
* Rule 185
* Adult mental health targeted case management (TCM)
* Children’s mental health TCM
* Vulnerable adults TCM
* Developmental disability TCM
* Child welfare TCM
* Relocation services coordination TCM
* Alternative care
* Home care case management
* The model for a uniform set of case management services that will include:
	+ Goals and outcomes
	+ Eligibility
	+ A uniform set of activities for all case management services:
		- Assessment
		- Planning
		- Referral
		- Monitoring
	+ Roles and responsibilities of case managers
	+ Qualifications and training of case managers
	+ Discharge criteria
* Identification of where the uniform set of services and professional standards need to vary based on the needs of a population or expertise needed to provide the service.

### Out of scope

The following issues are interrelated with the development of a core set of services and will inevitably surface during the meetings and conversations. However, it is out of scope to solve for these issues, which will be addressed within the broader case management redesign work:

* Development of statutory language
* Financial impact/costs
* Intersection with financial modeling
* Intersection with care coordination
* Role of lead agency/mental health authority and implications for choice
* Outcome measurement and development of quality assurance processes
* Technology architecture and IT development
* Implementation of a new case management service delivery model

## Description & Objectives

* The team will create an initial design for case management services which will be vetted with stakeholders throughout the process and after an initial design is created.
* The design will be a common platform defining all case management service types and activities.
* The group will build on the work and recommendations included in the 2013 legislative report, focused on the creation of a uniform definition and core activities for Medicaid-funded case management services, including service requirements and outcome measurement.
* The state and counties will have a shared understanding of the goals, values and need for service integration in the State of MN.

### Initial Design Team Member Responsibilities

* Attend monthly meetings, either in person or remotely via conference call, Vidyo conferencing, or ITV.
* Embrace and champion a model that has the person at the center of the design and is focused on the people, families, and the communities served by DHS.
* Use critical thinking and challenge assumptions.
* Review historical documents as provided by the DHS project team.
* Act as liaisons back to existing councils, boards, committees and workgroups who have interest in informing CM redesign planning.

### Commitment to how we will work together

* People experiencing services will be at the center of all discussions and considerations.
* The conversation will focus on creating positive outcomes for people receiving services.
* Opposing and supporting perspectives are welcome and needed.
* We will consider the impact of any recommendations on all types of Medicaid-funded case management.
* We will consider the secondary impact of recommendations on stakeholders and groups that are impacted by the delivery of case management services.
* We will acknowledge past challenges while focusing the conversation on solutions.

In order to inform the initial design team, the Case Management Redesign Project Management team will provide the following information:

* Background documents that summarize past work.
* Research regarding national examples of identifying and measuring outcomes and quality for design models and lessons learned.
* Documentation regarding current policies and processes of delivering case management services in Minnesota.
* Summary of federal requirements for federal financial participation for case management services.

## Commitment to equity

In January, 2017, DHS adopted a policy on equity that directs staff to incorporate equity analysis into the development of all policies and to authentically engage persons from cultural and ethnic communities before policy decisions are made. This includes Tribal nations. Tribal nations need to be engaged from the beginning on a sovereign nation to government level.

The goal of this policy is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation, which improves outcomes and reduces health and human services disparities and inequities for the people we serve.

The agency shall:

* Engage and empower all agency employees to advance equity through their daily work
* Identify standards, processes, metrics and systems of accountability to advance equity goals, including:
	+ Link agency service delivery of human services programs to the determinants of health;
	+ Institutionalize an equity focus in decision-making;
	+ Promote fairness and opportunity in agency practices;
	+ Collaborate across program areas; and
	+ Build community trust and capacity;
	+ Invest in human, capital and infrastructures to meet the needs of communities experiencing inequities.

## Values about stakeholder engagement

* The work will only be successful if the work is informed by various stakeholders, including people receiving services, families and caregivers, providers, payers, and others that are impacted by case management services.
* Case management services and delivery should be designed from a person-centered viewpoint—first and foremost guided by the people receiving the supports, their families or identified supports and the communities they live in. The first step in developing any case management service recommendation should be to understand the needs and desires of the person or family who will experience the service. At the policy level, this approach requires ongoing stakeholder engagement and feedback to identify, analyze and address needs.
* As we progress in case management redesign we are deeply committed to the following statement from the Governor’s Civic Engagement Plan in each phase of this process: “Communities of color, American Indian communities, LGBTQ communities and disability communities have previously been underrepresented in policy making. The failure to include these communities in the development of policy is detrimental to the long-term interests of the State of Minnesota. Effective meaningful engagement with all citizens in our state is essential to the functioning of Minnesota government. For engagement to happen, there has to be an intentional period of building trust with these communities. Trust must first be established with underrepresented communities before meaningful engagement can occur.”
* We will develop a plan to use the information provided to inform the development of process and policy.
* We will be clear about the scope of influence with each stakeholder group.
* We value long-term relationship building, and have ongoing conversations with communities instead of just hearing from them once.

Plan for stakeholder involvement in the design process
We will consult with stakeholders throughout the design process. In order to ensure that we are reaching a broad group of stakeholders, we will consult with existing groups such as the Cultural and Ethnic Communities Leadership Council (CECLC), HCBS Partner Panel, Mental Health Services Improvement Work Group, and the Minnesota Council of Health Plans.

We will plan community events focused on people receiving services in order to ensure that we are connecting with people in places and at times that work best for them.

During the design process, we will engage with the following:

* Leadership from DHS, counties, and Tribal nations
* Contracted provider organizations and case managers
* County social service supervisors and case managers
* Health plans
* Advocacy groups
* Non-profit organizations
* People we serve, and their family members, caregivers, and identified supports
* People that do not currently receive case management services but may be eligible
* Members of the community receiving direct services, members of their family, caregivers, identified supports, etc.
* Trusted community leaders

## Meeting schedule

* March 26, 2018 - 9:00-12:00   (DHS Lafayette, room 5139)
* April 23, 2018 - 9:00-1:00  (DHS Lafayette, room 5139) – Lunch will be provided
* May 14, 2018   – 12:30-4:30 (DHS Lafayette, room 5134)
* June 11, 2018   – 12:30-4:30 (DHS Lafayette, room 5134)
* July 9, 2018   – 12:30-4:30 (DHS Lafayette, room 5134)
* August 6, 2018   – 12:30-4:30 (DHS Lafayette, room 5137)
* August 20, 2018   - 1:30-4:30 (DHS Lafayette, room 5139)
* September, 2018– date TBD

The meetings will take place at the DHS Lafayette building to ensure that we have the technology available for people to join the meeting remotely. However, due to the interactive nature of the meetings, team members are encouraged to join by ITV or Vidyo if they are not able to attend in person.

## Initial Design Team Members

| **Name** | **Organization/Representing** |
| --- | --- |
| Andrew Johnson | DHS/Community Supports/ Disability Services |
| Cheryl Lundsgaard | St. David's Center for Child and Family Development |
| Dagny Norenberg | DHS/Community Supports/Disability Services |
| Deborah Ho-Beckstrom | Parent of person receiving case management services |
| Diane Marshall | DHS/ Community Supports/Adult and Children’s Mental Health |
| Elaine Carlquist | County Based Purchasing/ PrimeWest Health |
| Emily Schug | Dakota County |
| Gretchen Ulbee | DHS/Health Care/Purchasing and Service Delivery/Special Needs Purchasing |
| Janet Nilsen | Saint Louis County |
| Jennifer Thomas | Parent of person receiving case management services |
| John Sellen | Hennepin County |
| Kayla Nance | The Arc of Minnesota, Greater Twin Cities Region |
| Khu Thao | Touchstone Mental Health |
| Luke Simonett | DHS/Children and Family Services/Child Safety and Permanency |
| Mary McGurran | DHS/Continuing Care/ Continuing Care/Adult Protection |
| Mike Herzing | Hennepin County |
| Penny Pesta | Morrison County |
| Rachel Shands | DHS/Continuing Care/Aging and Adult Services/HCBS |
| Renee Donald | Restart, Inc. |
| Sheri Olson | Volunteers of America MN |
| Stacey Steinbach | Yellow Medicine County |
| Stacy Hennen | Grant County |
| Susan Kurysh | DHS/Health Care/Purchasing Service and Delivery/Benefits Policy |
| Susan McGeehan | MN Council of Health Plans |
| Tom Henderson | Brown County |
| Tracy Telander | HealthEast |
| Veronica Medina-Gillies | MN Brain Injury Alliance |

## Project Resources/Contributors

| **Name** | **Organization** | **Role/Expertise** |
| --- | --- | --- |
| Barbara Tuckner | MMB/MAD | Facilitation |
| Cat Rohde | DHS | Management Analyst |
| Jeffrey Hendrix | DHS | Business Solutions/Business readiness  |
| Jennifer Blanchard | DHS | Director- Community and Care Integration Reform |
| Karen Gaides | MMB/MAD | Note-taking |
| Leah Montgomery | DHS | Policy analysis |
| Lisa Cariveau | DHS | Project lead |
| Rebeca Sedarski | DHS | Community Engagement  |

##

1. On 12/18/13, CMS sent a letter to DHS saying that the rate-setting for mental health targeted case management is problematic because 1) the bundled payments make it possible that payments for some services that are not covered by Medicaid (for example, room and board) could be made; 2) county-negotiated rates (to private providers) do not demonstrate a uniform, state-wide rate setting methodology approved by DHS; and 3) federal law requires direct payment to the provider of the service and the current State Plan’s method for dividing up payments among a team of contracted vendors may not meet that requirement. Legislation passed during the 2017 legislative session related to mental health targeted case management that required DHS to submit an amendment to the Medicaid state plan.  As a result, CMS has raised concerns in a letter sent to DHS on 12/27/17 regarding case management, specifically related to county-negotiated rates. The Case Management Redesign Leadership Alignment team approved a draft timeline to submit to CMS as an initial response to their concerns. [↑](#footnote-ref-1)