Case Management in Minnesota

A Report to the Minnesota Legislature

Continuing Care Administration 444 Lafayette Road North, St. Paul, MN 55155-3872 651-582-1998

For more information, contact:
Minnesota Department of Human Services
Disability Services
444 Lafayette Road
St. Paul, Minnesota 55155-3872
(651) 582-1998

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Minnesota Department of Human Services
Continuing Care for Persons with Disabilities

February 12, 2003

Prepared by the Department of Human Services
Disability Services
444 Lafayette Road North
St. Paul, MN 55155-3872
(651) 582-1998

Legislative Report: Case Management in Minnesota

February 2003

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I. Executive Summary

This report is being submitted to fulfill the legislative requirements under Laws of Minnesota 2002, Chapter 375, Article 2, Section 48. The legislation requires the Commissioner of Human Services to study case management services for persons with disabilities in consultation with consumers, consumer advocates, and local social services agencies. The Commissioner is directed to report to the chairs and ranking minority members of the house and senate committees having jurisdiction over health and human service policy and funding issues on strategies that:

1) Streamline administration,
2) Improve case management service availability across the state,
3) Enhance consumer access to needed services and supports,
4) Improve accountability and the use of performance measures,
5) Provide for consumer choice of vendor, and
6) Improve the financing of case management services.

After careful consideration of the challenges inherent in the complexity of the issues and the limited timeline available, the Commissioner recognizes that we have an opportunity to step back and review the array of current case management programs for all public program consumers. We currently do not have "one system" of case management for targeted populations and recipients of home and community-based waivers. We have multiple forms of case management authorized under different programs serving more than 100,000 persons for whom we are spending hundreds of millions of dollars with little documentation of the value of this particular intervention. (See Appendix 1 for description of types of case management.) The need to improve case management services is not exclusive to persons with disabilities. There are similarities in the strategies to improve case management and service coordination across all populations in state public programs. Improvements to develop a system of case management will benefit all public clients.

The Department would like to undertake a review of the current patchwork of case management, with broad input from consumers, local social service agencies, Tribes, and consumer advocates, to improve case management services to benefit all targeted populations and recipients of home and community-based services.

The primary focus will be the case management services for targeted populations and home and community-based waiver program recipients.

The goal is a system of improved accountability and quality in case management services that assist public clients to navigate across the continuum of health and social services and programs and achieve desired outcomes.

This year, the Department proposes to lead a public process of regional meetings, convene discussion panels, and solicit expert advice to implement strategies at the state

and local levels that will improve both accountability and quality. The Department envisions a system that is built on clearly articulated expectations of case management and case managers. We need standardized reporting mechanisms to track and monitor performance and outcomes for all populations and the ability to enforce and reinforce. The system will use administrative resources more efficiently, remove barriers between funding streams, and eliminate "silos" in program administration. The system will build on elements of best practice across all populations and be respectful of specific needs based on age, geography, and disability. The system will enhance consumer access to necessary services and support consumer choice and self-direction. The Department recommends the following strategies:

- Establish a clear definition of case management;
- Establish common understanding that guides professional responsibilities for case management;
- Collect and report appropriate data for tracking and monitoring performance and outcome measures;
- Streamline administration;
- Enhance consumer access to necessary services;
- Support consumer choice and self-direction; and
- Establish enforcement mechanisms.

The emergence of person centered planning and consumer directed purchasing models, which the department supports, would be supported and enhanced if we are successful in implementing these strategies. Any purchaser, under any program, of case management services, the state, county agencies, or consumers, will benefit from these improvements to the current system. Strategies to improve our current case management system for targeted populations and home and community-based waiver recipients should focus on assuring the same key elements of quality and accountability, including access, informed choice, standardized reporting and financing, and consumer protection, across all programs and entities that provide case management whether through a local social service agency, tribe, or as a contracted service.

II. Background

Case management is a systematic process of ongoing assessment, planning, referral, service coordination, monitoring, consultation and advocacy assistance through which multiple service needs of clients are addressed. These key components of case management are implemented with considerable variation in the existing case management programs within the state of Minnesota. In an ideal world offering continuity, communication, and mutual support, perhaps case management would not be needed. However, as long as we live with a fragmented delivery system, case management will be one way to bring services to individuals according to their needs.

There is value to taking on the challenges of creating an accountable system of case management because case management services offer real benefits to recipients of public programs, their families, their providers, and their communities.

Consumer benefits include improved health and functional status, information about and access to needed services across the continuum of care, involvement in care decisions, and cost-effective care in the least restrictive setting. Family/caregiver benefits include the expertise and assistance of an experienced case manager, information and guidance that are helpful to making important decisions, referral to needed services, and emotional support.

Provider benefits include coordination of care with other providers, referral for persons to other needed services along the continuum, monitoring quality, conserving time through case management of non-medical needs, and input to development of care alternatives. Payer benefits include consumer satisfaction, appropriate substitution of lower-cost services for high-cost services, and avoidance of costly inpatient and institutional care.

In recent years, stakeholders have called for greater attention to the broader concept of *integrated care management.* This term is used to refer to efforts across the continuum of the health and social services programs and agencies that assure clients receive services that are appropriate to their needs, integrated across service settings and over time, and that support client specific and system-wide goals. The Minnesota Senior Health Options (MSHO) and the Minnesota Disabilities Health Options (MnDHO) programs finance and enhance an integrated medical care management services design for vulnerable populations enrolled in managed care health plans. MSHO and MnDHO offer successful demonstrations of experience that can provide guides to implementing strategies that will improve accountability and quality, including person centered planning and consumer directed purchasing, for targeted populations and recipients of home and community-based services.

Tribal entities currently provide case management services within the parameters of existing MA programs. In fact, they have sought, and received, statutory authority to provide case management services without the need of a county contract. They have expressed interest in increasing their capacity to provide these services in an effort to serve persons in a more culturally appropriate manner and to generate additional MA

revenue. Minnesota Tribes struggle with some of the same issues that the counties face in the delivery of these services. In addition, they have issues that are unique to their experience. As a stakeholder, Minnesota Tribes will need to be present in all discussions relevant to addressing the various issues discussed in this report.

Historically, state and county staff, in their roles as providers and payers, understood the benefits of case management, especially as evidenced in medical care. Over a period of years, advocates and program staff for different public program populations sought ways to expand funding and staffing to help their growing numbers of clients with increasingly complex needs. The case management options were implemented with good intentions to serve more people more efficiently and effectively. Formal evaluation and enforcement mechanisms gave way to concerns about burdensome administrative costs. With hindsight, we can see performance standards, monitoring, and enforcement should have been in place from the beginning.

The good news is that Minnesota has been successful in getting federal approval for expanded use of Medicaid funds for case management services. ***Unfortunately, the evolution of these case management initiatives, independent of one another, has, at times, resulted in ineffective practices at the point of service, development of program "silos" at the state level, and created confusion at the local level.*** As case management has evolved program by program, under different administrations, the result is a variety of eligibility/intake procedures, practice standards, provider standards, reporting and reimbursement methodologies. We have the opportunity to step back, look across the case management types, keep what is good, and build an infrastructure that is efficient and effective.

Prior to the enactment of key federal legislation, States could not provide case management as a distinct service under Medicaid without the use of federal waiver authority. However, aspects of case management have been integral to and a foundation of administration of the Medicaid program since its inception. Federal law has always required interagency agreements under which Medicaid recipients are assisted in locating and receiving services they need when others provide these services.

Expansion of Funding Options for Case Management Services:
Currently, the federal Social Security Act allows states to claim federal financial participation (FFP) for case management activities under the following areas:

1. Component of Another Service. Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. Since plan preparation is required as a part of home health services, separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. Administration. Case management services may be reimbursed as an activity necessary for the proper and efficient operation of the Medicaid State Plan, as provided in §1903(a) of the Act. The payment rate is either the 50 percent matching FFP rate or the 75 percent FFP rate for skilled professional medical personnel.

   There are two ways MA administrative dollars are paid for local social service activity in Minnesota: (1) As reimbursement to counties based on the Social Service Time Study (SSTS). Approximately 90 to 95% of these MA administration reimbursements are earned from activities such as outreach, eligibility determination, benefit determination, screening and assessments. With a small exception for MA eligible adults ineligible for targeted case management programs, these dollars exclude "service coordination" because that activity is reimbursed separately under targeted case management programs. (2) In addition, based on the Local Collaborative Time Study (LCTS), MA administration funds are combined with federal Title IV-E (Child Welfare) administrative funds to reimburse Family Service and Children's Mental Health Collaboratives in local areas for service coordination across county social service agencies, public health agencies, school districts, and corrections agencies. Of the $45 million earned by local Minnesota collaboratives in 2002, $19 million was from MA administration funds.

   Some additional funding to Tribes for case management activities is made through federal Title IV-E and state Indian Child Welfare Act (ICWA) grants.

The next two types of case management are the focus of this report. See Appendix 1 for further additional descriptive information.

3. Section 1915(g) Waivers for Targeted Case Management. The provision of case management services under this authority is "Targeted Case Management," an option a state may choose to deliver to a target population within the broader MA population. The targeted population is identified by: age, type or degree of disability, illness or condition, or any other identifiable characteristics. As further described in Appendix 1, Minnesota has chosen to expand funding for case management services to children in need of protection, adults and children with mental illness, adults with developmental disabilities, and persons in institutions in need of relocation assistance to community care. In addition, the State is allowed to identify "qualified case managers" for persons with DD or MI in order to ensure that the case managers for such individuals are capable of rendering needed services specific to each targeted population.
4. Section 1915 (c) Waivers for Home and Community –Based Services. Case management services may be provided as a covered service in an approved waiver for home and community based services to support vulnerable populations live in the community and avoid more expensive residential or

institutional placement. Under Minnesota's waiver, case management is a covered service with service description and service provider qualifications identified. Case management services must be part of any plan of care authorized for eligible clients.

This is not an exhaustive listing of all the programs that include case management as a component of service delivery. For example, the Prepaid Medical Assistance Program (PMAP) assumes medical case management activities in health plan payment rates. The Minnesota Senior Health Options (MSHO) program and the Minnesota Disabilities Health Options (MnDHO) program are specifically designed to reimburse and enhance case management services for the frail elderly and adults with physical disabilities. Both programs have been successful in integrating health and social services across the continuum of medical and long term care for vulnerable persons enrolled in managed care plans. Both programs have successful evaluation and accountability strategies that will be useful to guide changes in the Targeted Case Management and Home and Community Based Programs as proposed in this report. The MSHO and MnDHO programs have begun efforts to document the financial value of case management services. This information and experience will be a corner stone for Department efforts to reach its goal of improved accountability and quality in case management services for all targeted populations and recipients of home and community-based services.

Financing Methodologies and Payments:

Appendices 2- 5 illustrate the considerable amount of MA dollars used to finance case management in Minnesota. That dollar amount, along with the number of recipients, continues to grow but not as a direct correlation. Over a three year period the number of recipients receiving case management increased 22% while reimbursement expenditures over that same time frame have increased by 40% (CY99 – CY01).

Case management should be a means to achieve client goals and not an end objective for reimbursement.

Case management functions across populations, although very similar, have different rates of payment, in addition to using different units of payment. Furthermore, there are differences in rates paid under the same program between counties. This lack of consistency leads to difficulties in administration at the state level and frustration about the complexities and budgeting issues at the local level.

There is also concern regarding the methodologies used for determining program rates. The methodology for targeted case management (TCM) is based on the amount of time and resources spent rendering the service, the number of persons served and total county expenses. These rates are recalculated on a yearly basis. In contrast, tribes are reimbursed via a cost-based encounter rate that includes other non-case management services.

Home and Community-Based Services (HCBS) case management rates were developed years ago and have only been allowed to increase as authorized by the legislature. The

TCM rates consist of federal and county allocation with no state contribution. Conversely, the HCBS payment rates paid consist of state and federal dollars. Advocates and stakeholders have expressed concern with the above methodologies because the current methods used are resource-based rather than outcome-based. They feel that this creates incentives to over-utilize services and doesn't ensure that outcomes/goals are being met. Methodology differences do influence how services are delivered. The Department needs county and consumers input before any changes are implemented.

Counties have a significant financial stake in case management services as both a revenue source and as an expense. County funds support the provision of case management to the non-MA eligible groups. Additionally, counties are responsible for the non-federal portion of all the targeted case management rates. Advocates and other stakeholders have urged the department to seek funding alternatives to county property tax levies. Others have called this financing arrangement inappropriate because MA is an entitlement and a responsibility of the state, not the counties. Concern has been expressed about the potential improper county refusal of MA services because of budget constraints, and the need for appropriate alternatives to counties as the only vendor of case management services.

III. Proposed Strategies for Case Management Redesign

The Department proposes to use a public process in the next year and focus on proposed strategies to build consensus and agreement on changes to the current case management for targeted populations and recipients of home and community-based waivers that will improve accountability and quality across the continuum of health and social services.

Establish a Clear Definition of Case Management and Establish a Common Understanding of the Professional Responsibilities for Case Management

Currently, Minnesota does not have a clear and consistent definition of case management functions that can provide a foundation for measurable standards of performance or outcomes for populations being served in each program that pays for case management services. There are standards or expectations for the provision of case management that are appropriate to any program and to any provider of case management. With that foundation in place, specific standards can be developed to address unique needs of individual populations within the programs. The lack of definition and measurable standards for performance and outcomes results in

1. unclear expectations for consumers and other purchasers;
2. insufficient data and limited reporting;
3. uncertain standards for quality assurance and accountability; and
4. lack of enforcement

Issues that must be addressed in the planned public process include:

- Case Management as implemented in Minnesota programs can be considered to have two component functions: administration or "gate keeping" functions and service coordination functions**.**

The same person may perform these functions or they can be separated. Minnesota has a state-supervised, locally administered system of social services. Counties, and to a lesser extent tribes, are responsible for the "gate-keeping" functions of eligibility outreach, screening, intake, screening and assessment, and benefits determination. County and tribal employees also perform service coordination functions. Sometimes these entities contract out these functions to private vendors. This is more often the case for service coordination functions and it occurs more often in larger metro counties that have more options for contracting. Service coordination includes planning, identification of available and appropriate services, coordination of service provision across multiple programs, agencies, and assessments, advocacy, and on-going monitoring.

- Unique County Role

County leadership is essential to achieve a goal of improved accountability and quality in case management services. This is most especially true for any changes related to the expectations or standards of case management service provision. County governments have specific legal responsibilities for administration of programs related to case management functions, regardless of Medicaid eligibility. County staff do not have to be the provider of case management service, but counties do determine who will provide case management services.

- Case Manager Qualifications and Training

Counties are responsible for the safety and well being of the eligible persons in their care and, acting responsibly, counties have defined who is qualified to perform case management. In most cases the qualifications are incorporated into job descriptions for county employees and current regulation of personnel responsible for case management relate primarily to process. Case managers must be "qualified" by education, background and experience to serve a specific population and, although the different forms of case management are very similar in form and function, there is little consistency amongst the various forms regarding qualifications and training requirements. Accountability and quality improvements will require attention and consistency to training. This is an important responsibility of the State that has not been addressed for several years.

Currently there is little state oversight or monitoring of case management quality. Problems do surface through appeal situations. These individual situations can be rectified. There is not, however, a monitoring of the system. There are no clear standards for performance tied to expected outcomes. The current system is not able to

evaluate what a person needs and how well that is provided. There are variations in practice by region, by population served, and by type of case management

Without standards for accountability, consumers do not know what should be offered and the state cannot assure consistency statewide. Most persons eligible for case management are also eligible for services that cross social services boundaries, such as employment assistance, medical assistance, and housing assistance. Anecdotal evidence suggests that there are case managers who do not offer the full range of assistance because of a lack of knowledge or stresses from too high caseloads.

- Issues Related to Multiple Case Managers

Much more input is needed from county staff and the public to address fully and fairly the perceptions and problems raised by multiple program eligibility and multiple case managers for a single eligible recipient. For example, there are incidences of eligible persons with multiple case managers and no "lead" case manager. A client-centered approach would suggest that the Best Practice is to have a single or "lead" case manager who can plan and coordinate services for the "whole" person. The lead case manager assures access to and coordinates with other expertise in health, social services, education and employment The client is not broken into program pieces and services are used efficiently and effectively. Identification of a single, accountable case manager offers opportunities for efficiencies and improved quality. Consumer satisfaction is greatly increased when the client has a single, accountable, primary contact. The client is better served when they know whom to call every time.

Federal guidelines mandate that case management services be coordinated and not duplicated. Multiple case managers can lead to inadvertent problems in assuring financial integrity. A person may have more than one case manager but it is not acceptable to bill for overlapping services. With the proliferation of case management program options in Minnesota, it is getting increasingly difficult for the state to ensure that duplication is not occurring at the local level, and to a lesser extent, that services are being coordinated. Without improved reporting and a formal tracking and monitoring system, the Department has no way to ensure accurate payments.

In Minnesota, it is possible for a single person to be eligible for, and receive, more than one form of case management. Depending on the county, this often necessitates the recipient to have more than one case manager assigned to them. For example, a child with a Serious Emotional Disturbance (SED) would be eligible for Children's Mental Health Targeted Case Management. If that same child is at risk of out-of-home placement, he/she would also be eligible for Child Welfare Targeted Case Management. If the child meets additional waiver eligibility criteria, he/she would also be eligible for, and receive, a form of HCBS waiver case management. In this scenario, it would be possible for this person to have three different case managers assisting them – one for each program. The Department needs more public input to understand the staffing complexities, how to ensure primary responsibility if there is disagreement between case managers, and how to ensure that each client knows who to call every time.

Collect and Report Appropriate Data for Tracking and Monitoring Performance and Outcome Measures

Currently data collection is limited to enrollment and caseload figures, resource accounting for administrative time and financial billing, and reimbursement for service rendered. The newest targeted case management programs have begun to collect information on wait times (to see a case manager) and initial attempts to collect satisfaction information for evaluation purposes have been implemented in mental health. Overall, however, there is little or no documentation to support the value of case management. Identification of key performance and outcome measures is critical. Currently, the Mental Health Division is considering six nationally recognized "Evidence Based Practices." This is where all program areas should be headed. The proposed process to garner public and county input is necessary to the identification of meaningful measures. We expect that there are demonstrably effective performance standards that are appropriate for case management across any population, as well as standards that are best practices for specific populations. Stakeholder input and consensus is important to implementation.

Streamline Administration

The state, as supervisor of public health and social services, sets standards for quality, collects appropriate data, performs monitoring, reporting and enforcement. Currently, administration is by program area and, therefore, redundant at times. Separate administration adds confusion for county staff and reinforces the "walls" between programs. More can be done at the state level to centralize administration of case management programs and coordinate training efforts across all the different forms of case management. This will reduce inconsistencies in policy and program administration at the county level. An important aspect of the proposed process for public input will be the opportunity to build efficiencies. For example, data collection and financing methodologies could be made more consistent to reduce complexities and increase information. Satisfaction surveys could be coordinated and performed consistently once a year.

Enhance Consumer Access to Necessary Services

The proposed public process will be used to gather information and sort out issues related to caseload and the financing of case management services. There is anecdotal evidence that there is not consistent access to case managers across programs and across counties. In some counties eligible children and adults are required to wait months for attention from a case manager. There are delays in eligibility determination and then another delay in meeting the case manager and getting a plan for services. County workers may learn of the needs of children and vulnerable adults only when those needs have become very serious. Timely response is important To the extent the expansion of reimbursement for case management services the last few years was an effort to increase funding for county staff resources, how counties use reimbursement revenues is not well understood. In fact,

there are very few forms of case management that include maintenance of effort or other directions for use of the revenue generated by these benefits. The state presumes that the revenues to the counties are reinvested in staffing or other same program support for the continued generation of revenues but there is not sufficient documentation.

Caseload numbers are reported and can be used as an indicator of quantity served. It is not an indicator of quality because there is not a standard for appropriate caseload in most of the programs. (An exception is Targeted Mental Health services.) The state generally agrees that caseloads for county workers who do case management are very high. One interpretation is that case managers have many people on their caseloads who do not need case management services. It may also mean that there are too few case managers and they have too many people on their caseloads who need services. Case managers who have high caseloads can only react to situations as they arise; they are not able to meet with their clients regularly to plan and proactively assess situations.

The answer is not necessarily mandated caseload size. Caseload sizes should be guided by level of need and functioning. Assessment tools are being developed – and in some cases exist – that can be used to indicate level of functioning and level of service intensity. These tools can be applied to development of performance standards as well.

Support Consumer Choice and Self-Direction

Increasing expectations for more involvement by consumers in planning and directing individual care plans calls for changes in how case management is provided at both state and local levels across all programs. This is the fundamental change that has fueled the drive to redesign how case management programs are administered, financed, and delivered. Consumers and their families and caregivers want to be more involved in making decisions about providers and they want to be assured that they have all appropriate information. Responding to these expectations requires a shift in how case management is performed with some recipients and it requires an examination of the whole case management infrastructure as it relates to accountability and quality. The state and the counties want to support and expand consumer directed options but they agree that the current infrastructure does not have the necessary standards, data, monitoring and enforcement mechanisms in place to ensure informed purchasing, client safety, and appropriate outcomes.

IV. Recommendations

The Department recognizes the need to refine the current array of case management programs for targeted populations and recipients of home and community-cased services, including administration, service delivery, and financing. Expansions in services, growth in the numbers of persons served, consumer interest in self-directed care, and significant increases in expenditures have prompted an interest in change by all stakeholders. The proposed strategies for change will impact state, county, tribal, and consumer interests. The Department plans a multi-layered approach to seek information and consultation from informed county officials and staff, recipients and family members and caregivers,

Tribal representatives, advocates, and educators and researchers from all parts of the state. The Department plans a comprehensive process that will include regional meetings, panel discussions, focus groups, and expert presentations to solicit broad participation. The Department will report to the Legislature in February 2004 on the success and outcomes of this effort and steps taken toward the goal and proposed strategies.

The goal of a case management system for targeted populations and recipients of home and community-based waivers is to improve the accountability and quality of case management services that assist public clients to navigate across the continuum of health and social services and programs and achieve desired outcomes.

We recommend the following strategies to achieve this goal:

- Establish a clear definition of case management. The foundation of a system is a clear, articulated definition of the services to be performed.

- Establish common understanding that guides professional responsibilities for case management. There are standards or expectations for the provision of case management that are appropriate to any program and to any provider of case management. With that groundwork in place, specific standards can be developed to address unique needs of individual populations within the programs. We will have the ability to establish measurable standards, contract standards, for performance and outcomes. This will also be the basis for training and continuing education.

- Collect and report appropriate data for tracking and monitoring performance and outcome measures. Standardized reports across all programs, including financial reporting, will support the ongoing monitoring and evaluation necessary to sustain the system and the specific programs.

- Streamline administration. We have heard that the "silos" at the Department level creates disparities between program populations, redundancies, and confusion at the service level. Centralizing or combining functions can improve quality through performance measurement, data collection, reporting, and enforcement. Consistent direction can improve accountability.

- Enhance consumer access to necessary services. With clear expectations for case management and data to track and monitor performance, we can begin to sort out and address the issues and anecdotal evidence of problems with wait times, staffing and caseloads. With information we do not have now, we can establish expectations for consumers and purchasers and providers. With community input and expert assistance, we can expand use of assessment tools to document caseload need and staffing standards.

- Support consumer choice and self-direction. All purchasers will benefit from improvements described above. Clear definitions and expectations, standards for

performance and measurable outcomes, standardized reporting, and consistent enforcement will provide a solid foundation of quality and accountability for consumer choice and self direction.

- Establish enforcement mechanisms. Lacking appropriate data for reliable monitoring and performance expectations, there have not been consistent enforcement mechanisms in place. In a system it is necessary to "close the loop" and reinforce the expectations and standards established.

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Appendix 1

TYPES OF CASE MANAGEMENT IN MINNESOTA

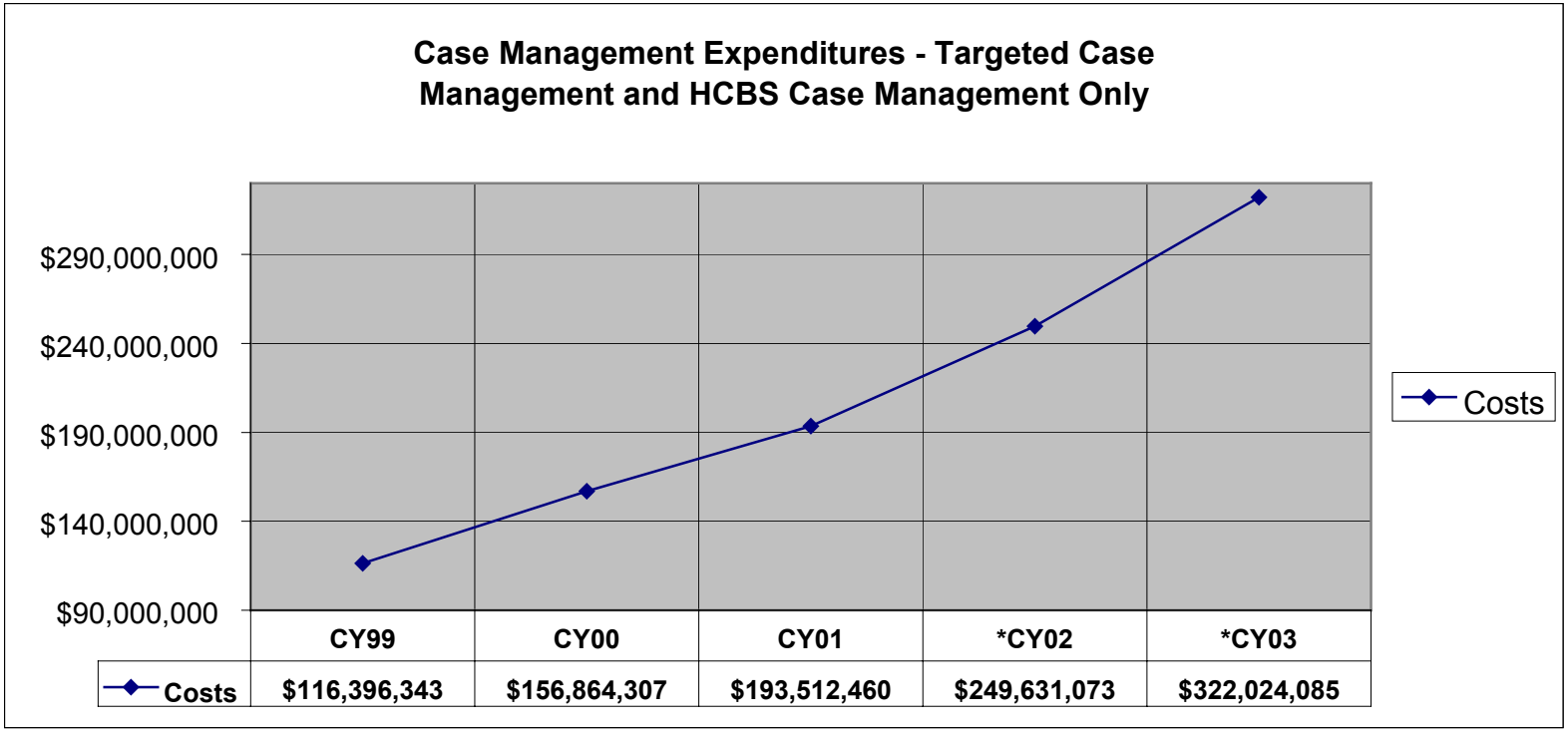
TYPE	TARGET POP.	VOLUNTARY?	PAYMENT	UNIT/RATE	COST (CY01)
Child Welfare Targeted Case Management (CW-TCM) *Implemented in 1994	Children under 21 that are: • at risk of out-of-home placement or in placement • at risk of maltreatment or experiencing maltreatment • in need of protection or services	NO	50% Federal 50% County 100% Federal for Tribes	Unit - 1 Month Rate – varies by county ($167 to $967)	Cost - $98,036,734 Recipients - 35,479
Children's Mental Health Targeted Case Management (CMH-TCM) *Implemented in 1991	Children with Severe Emotional Disturbance (SED)	YES	50% Federal 50% County 100% Federal for Tribes	Unit – 1 Month Rate – varies by county ($132 to $1,497)	Cost - $12,889,279 Recipients - 4,509
Adult Mental Health Targeted Case Management *Implemented in 1988	Adults with Serious and Persistent Mental Illness (SPMI)	YES	50% Federal 50% County 100% Federal for Tribes	Unit – 1 Month Rate – varies by county ($163 to $918)	Cost - $35,523,037 Recipients - 10,845
Vulnerable Adult and Developmentally Disabled Adult Targeted Case Management (VA/DD-TCM) *Implemented in 2002	Vulnerable Adults in need of Adult Protection or Adult with Mental Retardation/Related Condition	YES	50% Federal 50% County	Unit – 1 Month Rate – varies by county ($163 to $918)	
Relocation Targeted Case Management (R-TCM) *Implemented in 2001	Persons living in MA funded institutions who want to transition back to community	YES	50% Federal 50% State 100% Federal for Tribes	Unit – 15 Minutes Rate - $20.43	Cost - $40,039 Recipients – 95

Appendix 1

TYPES OF CASE MANAGEMENT IN MINNESOTA

TYPE	TARGET POP.	VOLUNTARY?	PAYMENT	UNIT/RATE	COST (CY01)
Home and Community-Based Waiver Case Management Implementation dates: EW Waiver– 1982 CADI Waiver – 1987 TBI Waiver – 1992 CAC Waiver – 1985 MR/RC Waiver – 1984 AC Waiver - 1981	Persons receiving waivered services through one of the following: • Elderly Waiver (EW) • Community Alternatives for Disabled Individuals (CADI) • Traumatic Brain Injury Waiver (TBI) • Community Alternative Care for Chronically Ill Individuals (CAC) • HCBS Services for Persons with Mental Retardation or Related Conditions (MR/RC) • Alternative Care (AC)*	NO	50% Federal 50% State * AC Waiver Case Management is 100% State Funded	Unit – 15 Minutes (all waivers) Rate: EW Waiver - $22.90 CADI Waiver - $22.01 TBI Waiver - $22.01 CAC Waiver - $22.01 MR/RC Wavier - $20.85 AC Waiver - $22.90	Cost - $47,023,372 Recipients - 40,086
HIV Case Management *Implemented in 1999	Persons with a diagnosis of HIV or AIDS	YES	Federal – Ryan White CARE Act State - Case Management Grant MA Dollars	Lump sum allocation to contracted vendors	Cost – $1,820,000 Recipients - 928

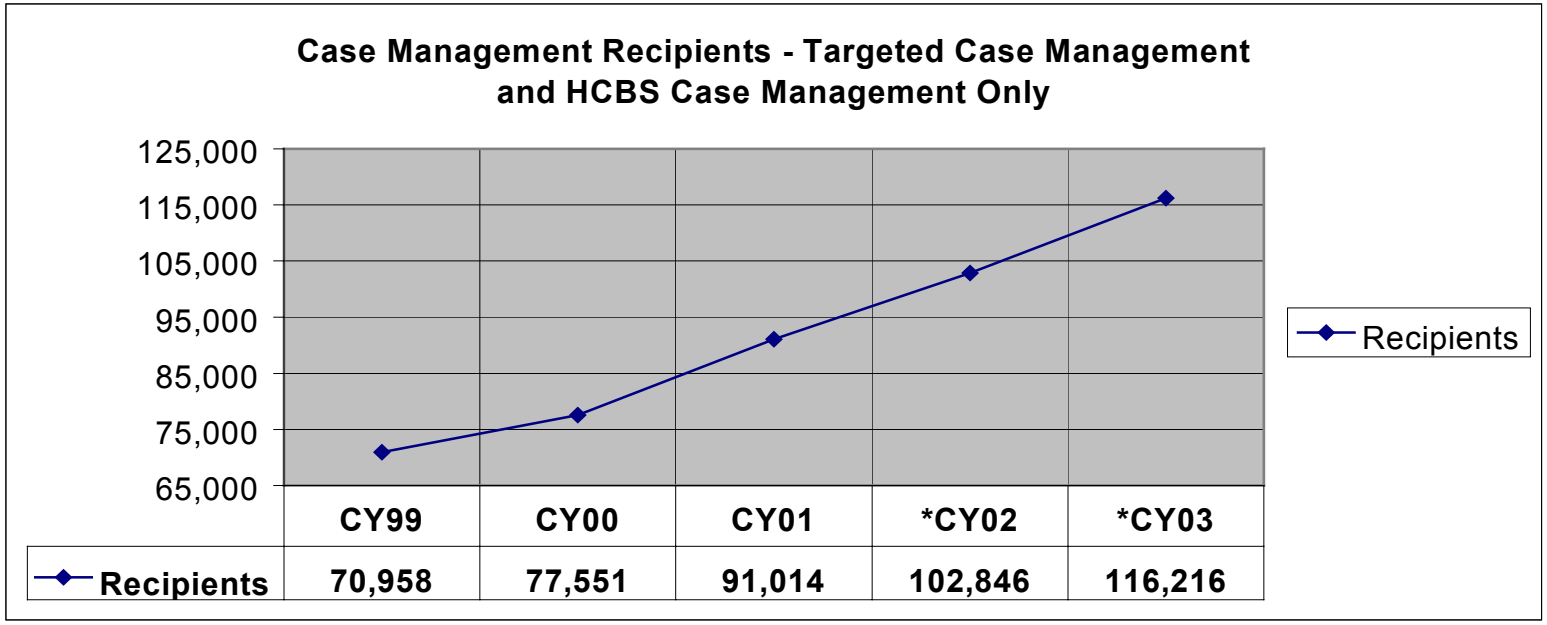
Appendix 2



	CY99	CY00	CY01	*CY02	*CY03
Costs	$116,396,343	$156,864,307	$193,512,460	$249,631,073	$322,024,085

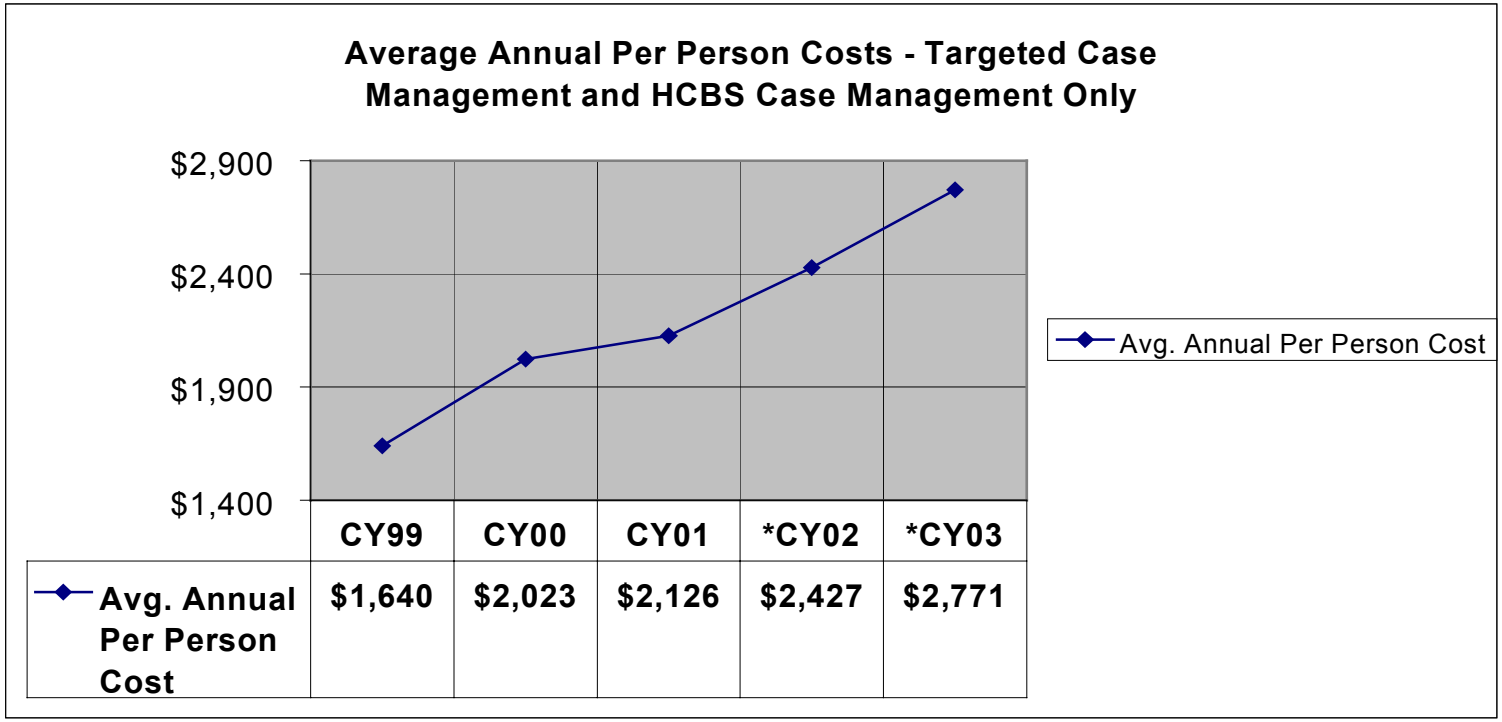
Source: Minnesota Department of Human Services, Executive Information System (December, 2002)
* CY02 and CY03 expenditures forcasted assuming 29% average annual growth.
** Totals include HCBS waiver case management and all forms of Targeted Case Management only.

Appendix 3



Source: Minnesota Department of Human Services, Executive Information System (December, 2002).
* CY02 and CY03 recipients forcasted assuming 13% average annual growth.
** Totals include HCBS waiver case management and all forms of Targeted Case Management only.

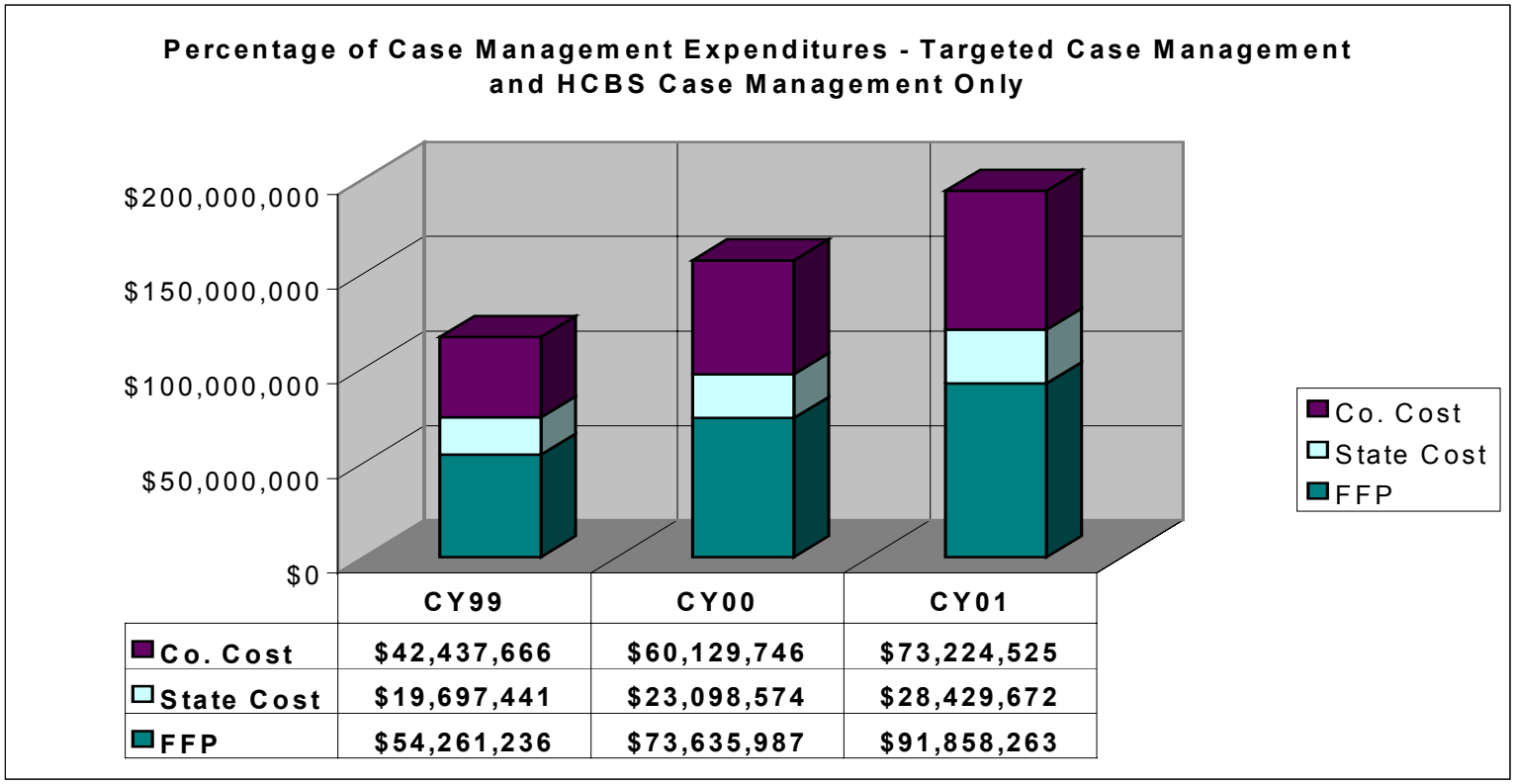
Appendix 4



	CY99	CY00	CY01	*CY02	*CY03
Avg. Annual Per Person Cost	$1,640	$2,023	$2,126	$2,427	$2,771

Source: Minnesota Department of Human Services, Executive Information System (December, 2002)
* CY02/CY03 Average Annual Per Person Costs assumes 29% average annual growth in expenditures and 13% average annual growth in recipients served
** Totals include HCBS waiver case management and all forms of Targeted Case Management only.

Appendix 5



	CY99	CY00	CY01
Co. Cost	$42,437,666	$60,129,746	$73,224,525
State Cost	$19,697,441	$23,098,574	$28,429,672
FFP	$54,261,236	$73,635,987	$91,858,263

Source: Minnesota Department of Human Services, Executive Information System (December, 2002).
* Totals include HCBS waiver case management and all forms of Targeted Case Management only.
** County costs are offset by state grants.
*** County costs reflect the 50% non-federal share of TCM rates and do not represent actual out of pocket expenditures.

Minnesota Department of Human Services
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