

MACSSA Members Feedback regarding the vision of case management

We sought feedback from the MACSSA Members by asking 3 questions and specifying that we were seeking director level feedback. We have summarized the answers we received below.

Question 1: If all “case management services” were to be provided in the same manner, how would that look?

Funding Structure:

*CM should be provided to clients based upon the needs of the client and the type of services they are receiving. (5)

*The State could model the funding amount to be the same per visit and the frequency of visits being based upon the needs of the client.

*An hourly rate billed for actual time spent, or 15 minute increments (5)

*Maintain funding so case management can be provided, don't increase requirements and decrease reimbursement (3)

*Fair and equitable payment for all caseload types (9)

*Fair and consistent from year to year (6)

*As we move to behavioral health homes unbundle the TCM rate so counties can continue to provide TCM, this is necessary to provide those services that are not fundable but are crucial for the people we serve. TCM services often intersect and counties can and should work with the BHH to integrate care for people we serve.

* Private Pay and/or Employer Based Health Insurance: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. This law should be updated to require that case management/care coordination services be included as part of the overall benefit set of covered services.

*Chemical Dependency Case Mgmt Clients: Promote that this become a part of Minnesota's Medicaid benefit set. Secondly, based on Washington and Olmsted's pilot project findings, enable CCDF/county match to be utilized for CD-TCM case management

***Unacceptable Funding Methodologies:**

a. Fee For Service (FFS): This methodology typically pays for a discrete set of activities, sometimes “tiered” by a billing or coding system that creates too many administrative tasks and burdens

b. Cost Shift: Typically, this methodology “shifts” costs currently funded by the state to county government as a strategy for the state to balanced its budget, e.g., DHS shifting part of IMD institutional

costs of inpatient hospitalization to the county.

c. Maintenance of Effort (MOE): Counties are required to maintain a fixed level of funding (fixed dollar or ratio) based on expenditures identified at some past point in time, e.g., Consolidated Chemical Dependency Treatment Fund (CCDTF), Basic Sliding Fee (BSF)

d. Mandates: "Mandatory" means counties are required by state or federal law to provide or fund a service, e.g., mental health, child support, income maintenance eligibility determination.

Policy:

- *DHS should set practice standards, minimum qualifications, defining meaningful outcomes, and have performance outcomes for all types of CM.(2)

- *Standardized billing and audits (2)

- *A common menu of services for all waivers

- *All providers should have access to the same systems, from county to MCO to contracted entities

- *Merge the definitions of case management (cm) and care coordination (cc) or eliminate the distinction between cm and cc. Although the 2 concepts have merged from separate disciplines of social services and health care, respectively, their core functions can and should be integrated and identically defined.

Question 2: What do counties need in order to provide high quality case management?

- *See MACSSA's "Counties Unique Role in Case Management: A MACSSA Policy Statement, July 2015, this was passed by the entire membership and was extensively vetted. It lays out our concerns.

Education:

- *Enhancements to the SW curriculum in colleges; more hands on work in the field during school, refined skills as it relates to technology and writing, increased soft skills like engagement, personal and professional accountability because of the vulnerable populations we work with. (2)

- *Specific program related case management training (4)

- *Utilize current structures like MSSA for training

- *More frequent training in all program areas, AMH specifically came up multiple times as did providing it in person not via webinar or ITV, lose discussion and learning from each other (8)

- *Supervisory training on leadership skills and secondary traumatic stress, and CORE training (4)

- *Well trained personnel (3)

- *Stable workforce and ability to recruit is imperative to cm (3)

- *Increased diversity in workforce

- *Practical, appropriate, and supportive clinical supervision

Funding and/or Caseload Sizes:

- *Adequate funding for staff so caseloads can be reasonable and social workers can provide person centered, high quality assistance. (6)

- *lower caseload sizes (9)

- *Simplification of service funding (3)

- *If counties are required to contract out case management to meet consumer choice requirements, or choose to do so, admin costs should be separate from case management rates.

- *Cost of supervision and support staff should be built into the rate so we can afford adequate supervisor/staff ratio and utilize support staff for appropriate paperwork and administrative duties. (3)
- *Case management caseload size/ratios should be based on evidence based practices

Paperwork:

- *Concise paperwork that is meaningful and effective, not redundant and cumbersome (6)
- *Reduce the length of assessments
- *simplify, simplify, simplify (2)
- *Establish clear practice standards:
 1. Case notes/charting that are standardized (see “Caseload Sizes/Ratios” above)
 2. Weighted/tiered caseloads, based on standardized assessments
 3. Standardized assessments
 4. Standardized billing protocols/audits from outside payer sources
- *Define meaningful performance measures guided by client’s progress/stability

Question 3: What would improve case management services in your county?

Staffing Concerns:

- *Better client to staff ratios (3)
- *Mandated/Recommended caseload sizes for all areas, not just MH, guidelines that are based in research
- *Adequate funding for appropriate ratio of supervisors to staff (6)
- *Continued work on finding ways to supporting case managers through expansion of para-professional and support staff by simplifying processes. (2)
- *Recruitment and Retention (4)

Needs from DHS:

- *Clear communication from DHS with expectations scaled to the population and reasonable timeframes
- *Standard documentation requirements across the board (2)
- *Quicker and more consistent answers for questions asked
- *Help building resource and service infrastructure, we are too often without services for those we need in our area and Statewide (4)

Technology:

- *DHS to support and assist in providing appropriate technology ie: EDMS, active online resources, systems that interface (SSIS,MMIS,METS,MAXIS,PHDoc) (3)
- *Working, reliable technology that truly supports the work, without that we will always be balancing technical knowledge with good case management practice.

Rule/legal changes:

- *Require the county of resident to provide CM , primarily for adults, if the person lives more than 50 miles from the county seat

*Difference in county size and location should be considered with the issue of consumer choice. Small counties do not have choice within reasonable distance and the county cannot often sustain a caseload if part of it is contracted out, this creating strained resources from all ends and impacting services.

Contracted Providers:

*They need additional training, assurances to decrease staff turnover, additional monitoring, better defined role and clearer expectations. This county's experience is that there is high turnover and little consistency for clients without much monitoring/quality control and a fair amount of work is still done at the county with no reimbursement.

Policy:

*Case managers/care coordinators are directly integrated into the local network of care and are therefore able to offer smooth coordination and seamless handoffs with other community provider, e.g., co-located in health care settings, schools, etc.

*For counties to maintain their primary position in providing, purchasing or overseeing case management/care coordination services.

*Counties are able to manage overall revenues and expenses across disciplines to sustain core services through hard economic times.

*Clients' choice must be balanced with managing "how" and "who" providers choose to serve. Counties cannot be left only with those that are non-Medicaid eligible, are under insured or are hard to serve.

*Counties, DHS, MCO's, consumers, families, providers and advocates reach consensus on the foundational elements, i.e., common definitions, funding mechanisms, assessment tools, caseload size criteria, for case management/care coordination to all current and future eligible populations:

1. Adult Mental Health Case Management
2. Children's Mental Health Case Management
3. Chemical Dependency Case Management
4. Supportive Housing-Homelessness Case Management
5. Child Welfare Case Management
6. Developmental Disabilities Case Management
7. Long-Term Care Services and Supports Waiver (LTSS) Case Management
 - a. Alternative Care (AC)
 - b. Brain Injury (BI)
 - c. Community Alternative Care (CAC)
 - d. Community Alternative for Disabled Individuals (CADI)
 - e. Developmental Disabilities Waivers (DD)
 - f. Elderly Waiver (EW)
8. Care Coordination Services
 - g. Minnesota Senior Health Options (MSHO)
 - h. Minnesota Senior Care Plus (MSC+)
 - i. Special Needs Basic Care (SNBC)

Other Documents Referenced by members:

- Case Management Legislative Report – 2003 (PDF copy enclosed with this document)
- [Redesigning Case Management Services for People With Disabilities in Minnesota – 03/08/07](#)
- [Case Management Roles and Functions of Counties and Health Plans – February 2008](#)
- [Case Management Reform for Persons with Disabilities in Minnesota – February 2011](#)
- [Minnesota Case Management Reform – February 2013](#)
- [Minnesota Case Management Reform – Revised June 2014](#)
- [MACSSA's Case Management Policy Papers](#)