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# MINNESOTA'S CASE MANAGEMENT SYSTEM FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

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Minnesota Department of Administration  
Management Analysis Division  
February 1991



STATE OF MINNESOTA  
DEPARTMENT OF HUMAN SERVICES

Human Services Building  
444 Lafayette Road St. Paul,  
Minnesota 55155-3815

July 29, 1991

The Honorable Jerome H. Hughes President  
of the Senate Minnesota State Senate  
Room 328, State Capitol Saint Paul,  
Minnesota 55155

The Honorable Robert E. Vanasek Speaker  
of the House Minnesota House of  
Representatives Room 463, State Office  
Building Saint Paul, Minnesota 55155

Dear Senator Hughes and Representative Vanasek:

As required by session Laws of Minnesota 1990, chapter 568, article 3, section 100, I am pleased to submit to you the attached report, "Minnesota's Case Management System for Persons with Mental Retardation and Belated Conditions," completed by the Department of Administration, Management Analysis Division.

One 1990 Legislature directed the Department of Human Services to make a report on service alternatives, including fiscal incentives, mandates, and rule changes that will encourage cost containment without adversely affecting the quality or the provision of services for persons with developmental disabilities. One of the developmental disabilities service areas to be addressed was the case management system.

In response to this, the Department contracted with the Department of Administration to conduct a service system alternatives study in the area of case management to complement other studies previously done that also focused on case management issues.

At the time of this study's completion, the definition of case management meant identifying the need for planning, seeking out, acquiring, authorizing, and coordinating services to persons with mental retardation and related conditions (Minnesota Rules 9525.0015, subpart 4). This includes monitoring and evaluating the delivery of services to and protecting the rights of persons. The federal definition as found in the Developmental Disabilities Assistance Bill of Rights Act of 1975 defines case management services as "...such services to persons with developmental disabilities as will assist them in gaining access to needed social, medical, education, and other services."



AN EQUAL OPPORTUNITY EMPLOYER

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This term includes follow along and coordination services as well. During the 1991 legislative session, the Minnesota Case Management Statute 256B.092 was changed to better recognize the functions of the county as both an administrator of services and a provider of case management to individual consumers. (See Recommendation #1.)

In response to other issues raised in previous studies and repeated in the Department of Administration Study on Minnesota's Case Management System, the Department of Human Services brought forward legislative initiatives during the 1991 session that addressed some of these issues. Recommendations from the Department of Human Services in response to the various studies and papers are as follows.

1. IN REGARD TO CLARIFYING ROLES AND DEFINITIONS, INCREASING EFFICIENCY, AND DEMONSTRATING ALTERNATIVES.
  - \* Separate and clarify the roles of case managers performing service related activities, administrative and gate keeping activities, guardianship activities and activities of the service providers.
  - \* Amend current case management statute and rules to streamline and increase efficiencies. Maximize the use of interagency teams that coordinate services.
  - \* Conduct pilot projects to clarify and demonstrate alternative provisions of case management services. Evaluate these pilot projects to recommend additional statutory and rule changes, as necessary.

These above listed issues were addressed in statute amendment during the 1991 legislative session.

2. IN REGARD TO FUNDING CASE MANAGEMENT AND ELIMINATING FISCAL DISINCENTIVES.
  - \* Propose service reimbursement methods which eliminate fiscal disincentives for county agencies to use less costly services and provide incentives that support state policy to use community based and integrated services.
  - \* Pursue alternative funding sources to assure adequate support for two case management administration and service activities.
  - \* Maximize and maintain the availability of federal funding for case management activities.

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3. IN REGARD TO PROVIDING TECHNICAL ASSISTANCE AND TRAINING.

- \* Develop procedures, manuals, guidelines, and formats to assist persons in providing case management services at the county level while working toward consistency with other social service structures, and rule simplification.
- \* Design caseload models to assist counties in making caseload assignments.
- \* continue and update training and technical assistance in case management and related areas.

Should you desire further information regarding this report, please do not hesitate to contact Shirley J. Patterson, Director of the Division for Persons with Developmental Disabilities, at 296-9139.

Sincerely,



NATALIE HAAS STEEPEN  
Commissioner

Enclosure

cc: The Honorable Linda Berglin, Chair  
Senate Health and Human Services  
G-9 State Capitol

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The Honorable Don Samuelson, Chair  
Senate Health and Human Services, Division of Finance  
124 State Office Building

The Honorable Alan W. Welle, Chair  
House Health and Human Services  
437 State Office Building

The Honorable Lee Greenfield, Chair  
House Health and Human Services, Division of Appropriations  
375 State Office Building

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# EXECUTIVE SUMMARY

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# EXECUTIVE SUMMARY

Case management has the potential to improve the quality of life for persons with developmental disabilities by providing individualized planning and developing alternatives to institutionalization.

However, as conceived and implemented, Minnesota's system is failing in some fundamental respects:

- The Minnesota Department of Human Services, the counties, individual case managers and other stakeholders do not agree on the value or mission of case management. Some see the case management mission as client advocacy and ensuring access to services. Others balance client interests with broader public interests and believe that cost containment is also fundamental.
- Because of Minnesota's historical reliance on Medicaid-funded institutional services, the individualized community alternatives that case managers are intended to use often do not exist,
- Although case management is delivered and largely funded by the counties, it is the state, through detailed regulations and paper-processing requirements, that describes how services are to be provided. It is reasonable for the state to require some county accountability, especially given the vulnerability of the population involved, but the existing requirements constitute overregulation by the state.
- Costs for case management for individuals with developmental disabilities in Minnesota increased by 123 percent (\$10.8 million) from Fiscal Year 1986 through Fiscal Year 1990, while the number of recipients grew by 19 percent.
- Most counties are not in full compliance with the state's paperwork requirements. County compliance with state rules would further increase costs without ensuring a commensurate increase in service quality.

This report examines various alternatives and models for case management, including the approaches used in 17 other states.

It concludes that Minnesota's case management system needs a new emphasis on cost containment and on innovation and experimentation, and that the state must redefine its relationship with the counties to place greater emphasis on assisting and less on controlling.

The report recommends experimentation with and development of a new model for case management that balances the following criteria:

- a focus on the unique needs of individual clients;
- inclusion of mechanisms for setting priorities and containing costs of the service system;



- simplification of the system and conformance to common sense;
- feasibility, especially with respect to federal funding requirements;
- facilitation of the transition away from large institutions and toward home- and community-based care;
- an increased level of authority and autonomy for case managers;
- reduced conflicts of interest for case managers;
- a limited state role as a direct service provider;
- enhanced fairness and equity for all individuals and groups dependent on public resources; and
- stability in relationships with case managers.

Although no models were identified that easily resolve all the weaknesses of the current system, this report recommends working toward an approach that uses a consolidated fund and case-mix strategy.

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# INTRODUCTION

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# INTRODUCTION

The 1990 Minnesota Legislature directed the Department of Human Services to study the costs of services to individuals with developmental disabilities. It further directed Human Services to assess service system alternatives in a number of areas, including case management. Specifically, the legislation said:

... [T]he commissioner of human services, in consultation with counties, the department of education, and the state planning agency, shall provide a report to the (legislature) that contains a description of all current state spending on mental retardation services, including special education services and vocational rehabilitation services .... The report must also identify service system alternatives, including fiscal incentives, mandates, and rule changes, that will encourage cost containment without adversely affecting quality or the provision of appropriate services. The proposals must include specific recommendations for semi-independent living services, respite care, case management, and day training and habilitation services (Minn. Laws 1990, Chap. 568, Art. 3, Sec 100).

Human Services' Developmental Disabilities Division contracted with the Department of Administration to conduct the spending study and the service system alternatives study in the specific area of case management. The two studies were conducted concurrently, but their reports are published separately. This report deals exclusively with case management alternatives. The companion report, *Public Expenditures for Services to Persons with Developmental Disabilities in Minnesota*, documents the spending study.

The agreement between Human Services and Administration described the case management report as "a description and analysis of alternatives to the current provision of case management services that could potentially contain costs while providing an acceptable level of quality and appropriateness."

Human Services selected case management for detailed attention because of general agreement among involved parties that changes are needed in this area.

## Overview of the report

The report is divided into seven major parts.

This introduction includes the legislative basis for the study, a description of the report outline and a discussion of the Department of Administration project team's methodology.

Part 1 provides background on the concept of case management. It describes the history and functions of case management and presents evaluative criteria that the project team recommends for assessing case management models and proposals.

Part 2 describes seven recent studies of Minnesota's case management system.

Part 3 looks at Minnesota's current system of case management for individuals with developmental disabilities. It provides historical perspective and describes the

system's strengths and weaknesses. It reviews Minnesota's case management rule (Rule 185) in theory and in practice.

Part 4 examines selected alternatives to Minnesota's approach. It relies heavily on the project team's research into other states' case management services for persons with developmental disabilities. The options are described in response to four questions:

- Who should receive case management?
- Who should provide case management?
- Who should fund case management?
- To what degree should case management be regulated?

Part 5 expands or combines alternatives into more comprehensive models of case management systems. Four models are described and evaluated according to the criteria from Part 1.

Part 6 contains concluding remarks and recommendations.

A description of case management systems in other states is included as an appendix.

This report of the Department of Administration differs from previous reports in at least two ways. First, it attempts to address major areas of disagreement on how the system should be improved, by examining and incorporating the views of a wide variety of persons involved in studying, conducting, administering or receiving case management services. Second, this report focuses on alternative methods of conducting case management. Alternatives for components of the system are described and evaluated, as are models for making systemwide improvements in case management systems.

## Methodology

A team of seven consultants and analysts from Administration's Management Analysis Division conducted this study (as well as the spending study published separately). They worked in association with the Developmental Disabilities Division of Human Services. The conclusions and recommendations in this report reflect the views of the Management Analysis Division.

The project team members were William Clausen, Sharon Coombs, Gail Dekker, Laura Himes Iversen, Scott Nagel and Paul Schweizer, led by Kent Allin. Assistance was provided by Charlie Ball, Carol Glaser, Mary Krugerud, Jill LaFave, Karen Patterson and Mary Williams,

The team's work relating to case management issues included the following activities:

1. A literature search on case management and the human services system for developmental disabilities.
2. Interviews of experts and interested parties about case management and service system alternatives.

3. Thirteen focus groups with seven to 17 parties interested in case management and service system alternatives:
  - People with developmental disabilities
  - Parents of people with developmental disabilities
  - County case managers
  - County social service directors
  - Day program providers
  - Intermediate care facilities for the mentally retarded and waived service providers
  - Semi-independent living service providers
  - Regional treatment center employees
  - A Greater Minnesota issues group held in Marshall
  - Developmental disabilities advisory committee to Human Services
  - Special education advisory committee to the Department of Education
  - Supported employment advisory committee to the Department of Jobs and Training
  - Human Services staff that monitor Rule 185 compliance
4. Site visits to the following places providing direct services to persons with developmental disabilities: Brown House and DeMar Children's Home (Coon Rapids), Cambridge Regional Treatment Center, Focus Homes (Maplewood), Hammer Residences (Wayzata), Kaposia, Inc. (St. Paul and Minneapolis), Nekton, Inc. (St. Paul and Minneapolis) REM, Inc. (Marshall), Renville County Community Residence (Bird Island), Rum River Ornamental Products (Isanti) and Thomas Allen, Inc. (West St. Paul).
5. A series of five meetings with a project advisory group of interested parties.
6. Research of selected topics, including federal financing of case management and state monitoring of Rule 185.
7. Surveys of other states with respect to case management practices.
8. Development of evaluation criteria for case management models and proposals.
9. Analysis of the data collected.
10. Evaluation of alternatives and development of conclusions and recommendations for this report.

The project team acknowledges and commends the significant contributions made by the many participants in this process.

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Part 1.

## OVERVIEW OF CASE MANAGEMENT

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# OVERVIEW OF CASE MANAGEMENT

## History and theory

Prior to the 1970s, prevailing wisdom dictated that people who needed assistance in carrying out the activities of daily living should be served in institutional settings. Public financing for helping those persons was used almost exclusively to pay for care in institutions. Persons with developmental disabilities, the elderly and people with mental illness were often placed in state hospitals or nursing homes, not because that level of care was needed, but because that was the only affordable option available to them.

In the 1970s, it became widely acknowledged that many persons living in institutions could be better served in the community. Pressure from advocates, clients and the legal system led to more funding for home- and community-based care.

Although non-institutional services were badly needed, their creation complicated the service system. Different non-institutional services were furnished by different providers, were funded by different sources, and were associated with different regulations and eligibility criteria. Case management evolved as a means to assist clients in evaluating and selecting appropriate services, and, in some cases, to control service cost and utilization.

In 1978, the 1975 Developmental Disabilities Assistance and Bill of Rights Act was amended to include case management among its priority services. By 1990, case management had been incorporated into numerous pieces of federal legislation, such as the Social Services Block Grant, Education for All Handicapped Children Act, and the Community Mental Health Centers Act. Case management is now provided ~ formally or informally ~ by numerous public and private agencies to many segments of the population, including persons with developmental disabilities, handicapped children and the elderly.

## Definitions of case management

Definitions of case management vary considerably, depending on the population to be served, and the intended purpose and scope of services provided. Often, case management is defined as *a service to assist persons in evaluating, coordinating and obtaining needed or desired services*. For example:

Case management services are those that will assist persons with developmental disabilities in gaining access to needed social, medical, education and other services (Developmental Disabilities Assistance and Bill of Rights Act of 1984).

Case management is a mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program for meeting an individual

client's needs for care (Austin, 1983\*).

Case management means the coordination of resources across agency and professional lines to develop and attain needed or desired individual goals, objectives or services with maximal individual/family participation in order to maximize the quality of life of the individual served in the least restrictive manner (State of Ohio, 1990).

In other instances, case management is defined more broadly as *a process for managing the delivery, cost and utilization of services available to clients*. This definition focuses on the entire service delivery system, and includes goals for meeting client needs *and* for controlling the cost and use of services. For example:

Case management is a statewide process by which the department directs, coordinates and monitors services to persons with mental retardation from the time that the person enters the system to the time at which they are discharged (State of Connecticut, 1986).

Case management is a business in which the best possible match between available service responses and the identified needs of individual clients is arrived at, with care tailored to need in a way that, to the extent possible, meets both the fiscal requirements of the system and the preferences of the particular client (Melemed, 1985).

When case management is funded as an administrative activity under Medicaid (one of several Medicaid options) it is to help assure the "proper and efficient" administration of the Medicaid program (HCFA, 1990).

Case management for the elderly is designed "to control long-term care expenditures by providing less costly alternatives to institutionalization and easier access to community-based and in-home care; contain costs and control utilization by targeting those in greatest need of long-term care services; and to help elderly persons and their families negotiate a fragmented and often confusing long-term care system and arrange for the most appropriate type of service" (Polich et al., 1989).

These definitions reflect the differing views that clients, policy makers, providers and taxpayers may have regarding how case management systems should be designed and operated. As noted by Healy (1990):

The state, i.e., the Department, has a duty to more than individual families. It must account to higher administrative authority, the legislature, taxpayers. Since its resources are "subject to appropriation," it must be able to assure that scarce resources have been fairly allocated... Families understandably don't care how resources are allocated or by

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•Complete references can be found on Page 77.



whom as long as the system responds to them. They will want "case management" to be its advocate, to maximize its benefits, to be accountable solely to them. The individual case manager... will want to do the most possible for the individual families .... When the "case manager" is a state (or county) employee, the desire and commitment to do as much as possible for the family potentially conflicts with the employee's responsibility to carry out the tasks the state (or county) needs performed (e.g., data collection, utilization control).

## Case management components

Case management for persons with developmental disabilities involves a number of key components or functions. Systems based on a service definition of case management typically do not include or emphasize the cost containment component.

- **Intake** -- Intake involves the identification and diagnosis of clients and determination of their eligibility for services. It may also involve outreach activities or information and referral.
- **Needs assessment** -- This function identifies a client's need for services by assessing preferences, skills and behaviors as well as factors (for example, environmental and medical) that affect development of skills and behaviors.
- **Individualized planning** -- The planning process reviews the client's diagnosis and needs, and identifies actions to address the needs and preferences. It can involve priority setting, development of long- and short-term goals or identification of barriers to implementation. Planning will most often result in a written document - the service plan - that identifies potential service providers.
- **Coordination of services** -- This function involves implementing the service plan. Clients are linked with appropriate providers, and contracts are developed to ensure that services are consistent with identified needs.
- **Monitoring** -- Monitoring includes follow-up activities, such as evaluating services and periodically reassessing needs.
- **Advocacy** -- Advocacy is the representation of client interests and protection of client rights. The functions described above are more or less sequential; advocacy can occur at any stage of the case management process.
- **Cost containment** -- Cost containment strategies within case management systems may involve seeking out less expensive alternatives to costly types of care (for instance, in-home vs. institutional care), setting caps on the costs associated with the implementation of clients' individual plans, and limiting the supply of certain types of costly services.

This report uses a broad-based definition of case management that includes all of the above components.

## Evaluation criteria

The project team - relying on data and insights from the literature review, the spending study done in conjunction with this study, interviews, focus groups and site visits -- developed a set of criteria to screen and evaluate case management models and proposals. These criteria attempt to recognize the legitimate interests of all affected parties.

Given the inevitable tension between two important values -- quality service to individuals and cost containment, the criteria may appear contradictory. The best models for a case management system must balance these interests and recognize that the most appropriate services may not always be the most expensive.

The criteria are organized by level of significance: critical, important and desirable.

### Level I criteria (critical)

#### **Does the case management model focus on the unique needs of individual clients?**

Any new case management system must attempt to shift the emphasis from providing the services that happen to be available or affordable to providing the services that are responsive to individual needs. It should focus on service recipients as unique individuals and respect people's limits as well as their potential. It must ensure an adequate level of protection to this vulnerable population but cannot be reasonably expected to guarantee risk-free lives.

**Does the case management model include mechanisms for setting priorities and containing the costs of Minnesota's service system?** Any new case management system must balance the interests of service recipients and taxpayers. Cost containment is necessary not only to appease taxpayers but to ensure that sufficient money is available to finance essential services for persons with developmental disabilities during an economic crisis, including services to new clients. Case management should be the tool for setting priorities and making prudent choices within managed budgets at the individual client level.

#### **Does the case management model simplify the system and conform to common sense?**

Any new case management system must strenuously avoid "solving" current problems by further complicating the process. Goals must include increasing flexibility and eliminating duplication. Adding agencies, individuals or paperwork should be done only for extremely compelling reasons.

**Is the case management model feasible?** Are there any insurmountable barriers to implementation? Any new case management system must meet federal regulations to ensure federal financial participation. Serious exploration of creative options will require negotiations with federal agencies and consideration of waiver or demonstration project strategies.

Any new case management system must also recognize the interests of consumers and counties. They should be respected partners in the system's development and implementation if there is going to be a successful change process.

**Does the case management model support the transition away from large institutions and toward home- and community-based care?** Any new case management system should enhance a client's ability to live in a less restrictive environment and should conform to the social policy directions set by public policy makers.

## **Level II criteria (important)**

**Does the case management model give case managers a level of authority and autonomy consistent with contemporary management theory?** Any new case management system should recognize that professionals are motivated to achieve superior performance by doing meaningful work in an environment of trust, participation and creative problem solving.

**Does the case management model address conflicts of interest within the case manager role?** Any new case management system should reduce a case manager's role conflicts, particularly with the contradictory missions of conserving public resources and advocating a client's interests. If conflicts cannot be eliminated, the system should provide at least broad direction to the case manager attempting to balance these demands.

**Is the case management model consistent with the state's limited role as a direct provider of services?** Any new case management system should continue to limit the state's role to leader, overseer and care provider of last resort, and should avoid involving the state in routine case management activities on behalf of individual clients. Human services case work is more appropriately handled at a local level.

## **Level III criteria (desirable)**

**Does the case management model enhance fairness and equity within the system for individuals with developmental disabilities and across service populations?**

Any

new case management system should help balance public resource commitments from one developmentally disabled person to another. It should also assist the state and counties in meeting the needs of various other vulnerable populations by effectively managing costs and utilization of services.

**Does the case management model promote stable and consistent relationships between clients and their families and the case managers?** Any new case management system should aim to reduce turnover in case managers. Increased work satisfaction should positively affect the quality of client services.

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Part 2.

## RECENT REPORTS ON MINNESOTA'S CASE MANAGEMENT SYSTEM

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# RECENT REPORTS ON MINNESOTA'S CASE MANAGEMENT SYSTEM

This study included a comprehensive review of state and national literature on case management, to increase the expertise of the study team and to ensure that the study would complement, not duplicate, previous work. This part highlights seven of the last decade's major reports related to Minnesota's case management system.

Previous reports have agreed that there are major flaws in the current case management system, and that the system needs to be changed. Reports generally agree on a need for more training of case managers, and a need for improved models for case management. There is disagreement, however, regarding the importance of reducing caseload levels, which models should be implemented, and how Rule 185 should be modified. (Minnesota's primary rule for governing case management is commonly referred to as Rule 185. It is formally referenced as M.R. 9525.0015 through 9525.0165, "Case Management Services to Persons with Mental Retardation.")

## **Minnesota Case Management Study, University of Minnesota, 1988**

One of the most recent and detailed, this report presents the survey results of 332 county human service directors, case management supervisors and case managers regarding case management practices in Minnesota, gaps and duplication in services, barriers to effective case management, training needs of case managers, and recommendations for improvement.

The most serious barriers mentioned by survey respondents were amount of paperwork, large caseloads and the number of meetings case managers were required to attend. Other frequently cited barriers included staff shortages, lack of program and service options, lack of residential options, and insufficient funds or restrictive use of funds.

The report's recommendation section notes that "the review of literature failed to identify a case management model which would resolve all the specific issues related to an effective service delivery system." The report recommends that the state consider reducing caseload ratios to one case manager for 30 clients, at an estimated cost of \$7.4 million. The report also recommends that paperwork be reduced (perhaps through computer-assisted programs) and that case manager training be improved.

## **Study of Case Management Ratios for Case Managers Providing Services to Persons with Mental Retardation and Related Conditions, Greystone Group, Inc., 1988**

This study was conducted in 1987 and 1988 in response to legal challenges and the view stated by many reports and individuals that large caseloads negatively affect the quality of case management services.

The study found that the average caseload in June 1988 was 54.8 per case manager, up 12.6 percent from July 1987. The study also found that caseload ratios *do not* correlate with service quality as defined and measured in field and service plan reviews, possibly, the authors suggest, because cases vary in terms of complexity and time required to manage them. Other possible reasons were that some people work faster when they have more to do, high quality service providers can make a case manager's job easier, and some counties have more office automation than others.

The Greystone study also looked at the correlation between compliance with Rule 185 and a variety of service quality criteria. It reported significant relationships between compliance and overall service quality, informal supports, consumer satisfaction, placement in the least restrictive environment, and community integration. When no correlation was found between Rule 185 compliance and criteria such as functionality, generalization and age appropriateness of services, the study recommended that the Department of Human Services "attempt to find out why, so that a policy-based predictor for these factors can also be established."

### **Commissioner's Task Force Report, 1988**

The Commissioner of Human Services' Task Force on Mental Retardation and Related Conditions found that more training, especially value-based training, is needed for case managers. The task force recommended more funding for fuller implementation of Rule 185, and more monitoring for case management effectiveness and client satisfaction.

### **The Case Management Team: Building Community Connections, Metropolitan Council, 1987**

This report cites problems related to case management -- heavy caseloads, the need for services exceeding a county's resources, the amount of paperwork required, and the travel time needed to complete case management, especially in rural areas. This report also found problems with Rule 185:

Minnesota's Rule 185 specifics what case management services are to be provided and minimum standards for how to provide them. The rule gives little indication of how to use case management services to obtain direct services that promote measurable changes in independence, productivity, and community integration.

The report offers four recommendations that emphasize the role of case management in meeting client needs: Case management should be comprehensive and should include lifelong planning and accessing of individualized services and monitoring results of the services provided; case managers should keep the client's needs paramount and select and monitor services that help clients grow in their ability to make decisions and express their preferences; resources should be adequate to recruit, train and retain qualified case managers; and caseloads should be allocated on the basis of clients' levels of need, with a maximum ratio of 1:25 for individuals who are severely handicapped.

## **Governor's Planning Council on Developmental Disabilities Reports, 1985 and 1990**

Recent reports by the council have noted that case managers mean well but lack knowledge, and that caseloads are too large. The council's recommendations include increasing the amount of time case managers spend with clients and making case management approaches more consistent. The council also recommends implementing a model case management program and defining case management alternatives.

## **Case Management: An Integrated Model, Health Planning and Management Resources, 1983**

This report calls for an integrated model for case management, where systems for different populations are consolidated. It is the author's contention that it is "unworkable" to have different case management models for each population at the local level, since the majority of Minnesota counties have three or fewer adult service workers who must deal with five target populations (aged persons and persons with mental retardation, a chemical dependency, mental illness or physical disabilities). The integrated model is similar to other models of case management, consisting of assessment, development of a client plan, allocation of resources, service coordination, monitoring, reassessment and evaluation.

The report recommends:

- that the state implement an integrated case management model applicable to all adult target populations;

- that case managers not also be deliverers of services;

- that county staff receive education regarding the role of case management;

- that the Department of Human Services be responsible for training case managers, with ongoing training provided in technical and community colleges; and

- that caseload standards be developed after the activities related to case management are better defined and more data is available.

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Part 3.

MINNESOTA'S CURRENT  
CASE MANAGEMENT SYSTEM

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# MINNESOTA'S CURRENT CASE MANAGEMENT SYSTEM

## Description

Minnesota's case management system was created for the same reason that many states established systems in the 1970s and 1980s - the number of community-based alternatives was expanding and clients needed help in evaluating and using services.

Although Minnesota has followed a national trend in developing case management services, Minnesota's case management and developmental disability service systems have been shaped by state-specific circumstances and regulations. Milestones in the development of Minnesota's systems include the *Welsch v. Likins* legal action that led the state to emphasize non-institutional alternatives, the passage of the Community Social Services Act that created county-based delivery systems, and the securing of a Medicaid waiver that gave the state additional funds for case management and other home- and community-based services (Table 1).

Current law requires that case management services be provided to all individuals with developmental disabilities who need medical assistance or social services. The statute defines "case management services" as "limited to diagnosis, assessment of the individual's service needs, development of an individual service plan, specification of methods for providing services, and the evaluation and monitoring of the services identified in the plan" (M.S. 256B.092, Subd. 1a).

In Minnesota, counties are responsible for providing case management services. A specific person must always be identified by the county as an individual client's case manager. A county may provide the services directly or under contract with another county or other provider of case management services. With some exceptions, the county may not purchase case management services for an individual from a provider of other services to that person.

## Rule 185

The Minnesota Department of Human Services provides direction and oversight of case management primarily through what is commonly called Rule 185 ("Case Management Services to Persons with Mental Retardation"). Rule 185 was promulgated in 1977 and has been revised several times. Statutory changes made by the 1990 Legislature will require further amendment of the rule.

Rule 185 was implemented to ensure that each eligible person with a developmental disability "receives a diagnosis and assessment of current condition, and that, based on the information gathered, services are designed, arranged, provided, and monitored so that the services meet the level of the person's need in the least restrictive environment and in a cost-effective manner" (M.R. 9525.0025, Subp. 2).

Case management services are defined as "identifying the need for, planning, seeking out, acquiring, authorizing, and coordinating services to persons with

mental retardation." It includes "monitoring and evaluating the delivery of the services to, and protecting the rights of, the persons with mental retardation" (MR. 9525.0015, Subp. 4).

Rule 185 was written in large part to specify county responsibilities and standards for case management, and to hold county agencies accountable for meeting those standards. According to the statement of need and reasonableness for rule revision in 1986, rule revisions were required because the rule had not been strictly enforced and "clearly was followed to varying degrees" by the counties. The statement of need found that the "lack of accountability was the central reason for the lack of movement from institution to the community."

To increase county accountability, rule revisions in the 1980s continued to make the rule more specific about how counties should conduct case management. The 20-page rule lists what must be included in the case management process, how and when individual service plans are to be developed, how and when case managers should conduct assessments and evaluations, and what case managers should do to ensure quality of services. Other components of the rule include a description of the appeal process, and education and training standards for case managers.

The rule reflects the state's view about the importance and role of the case manager in Minnesota's developmental disability system. According to the 1986 statement of need, fundamental case manager roles are administration, direct service, coordinating, monitoring and advocacy. Within these roles, it is expected that case management will assist the county and state in containing costs:

Currently in Minnesota, approximately \$250 million in federal, state and local money is spent on a per annum basis to serve persons with mental retardation. Because the concept of identifying a centrally responsible person to coordinate services (and act as an agent for the county to authorize services) is the method by which the Minnesota Legislature chooses to operate service delivery systems, the case manager is in a position to have a direct impact on the amount of money spent for (developmental disabilities) services. By actively and effectively providing case management services... the case manager can reduce and prevent inappropriate use of resources and provide less expensive and more appropriate services for persons with mental retardation.

The Department of Human Services recently drafted revisions to Rule 185 that were intended to reduce paperwork and allow case managers to concentrate their efforts on high-priority activities. The proposed revisions have not been enacted. However, one of the suggested revisions -- that the client's individual habilitation plan be incorporated into the client's individual service plan — was passed in 1990 legislation. Legislation that same year also attempted to address county concerns about fiscal responsibility. Prior to the revisions, the rule was interpreted to mean that counties must fund all the services specified in the individual service plan. At present, counties are still mandated to provide case management and day training and habilitation services, but do not have to fund additional services if they do not have the resources. The burden is on the counties to document good-faith efforts to provide services and seek alternative funding sources (M.S. 256B.092, Subd. 1c and 1d).

**Table 1. Highlights in the development of Minnesota's case management and developmental disabilities service systems**

- 1974** In *Welsch v. Likins*, a federal district court in Minnesota rules that residents of Cambridge State Hospital have a constitutional right to treatment and care in the least restrictive environment.
- 1979** The Minnesota Community Social Services Act is passed, laying the foundation for a county-based delivery system. This act gives counties authority over the funding, planning and administration of community social services. County boards are made responsible for an assessment of the needs of each person applying for services, for protection of the safety, health and well-being of individuals, and for provision of a means to facilitate access to appropriate services for people with disabilities.
- 1980** The Welsch Consent Decree requires that the State of Minnesota reduce the regional treatment center population of persons with mental retardation to 1,850 by 1987, improve overall conditions and staff/resident ratios, and develop community services for persons with mental retardation who are released from regional treatment centers.
- 1983** The first grants are made available to counties to provide semi-independent living services in order to reduce the number of persons with developmental disabilities who are in intermediate care facilities for the mentally retarded (ICF/MR). Also, a moratorium is placed on ICF/MR beds, so that the total certified capacity would not exceed 7,000 beds on July 1, 1986.
- 1984** Minnesota obtains its Home- and Community-based Services Waiver of federal Medicaid regulations, allowing the state to provide a broader range of more flexible services outside institutional settings.
- 1985** The Other Related Conditions Bill is passed. It uses a functional definition of disability and defines "other related conditions" to include certain persons with autism, cerebral palsy and epilepsy.
- 1989** The Department of Human Services and the state employees' unions negotiate a settlement on the future of regional treatment centers. Among other things, the agreement calls for a six-year relocation effort during which all but 95 of the 1,400 persons with mental retardation or related conditions remaining in the centers are to move into private or newly developed state-operated community homes.

**Source:** Taken in part from *A New Way of Thinking*, Governor's Planning Council on Developmental Disabilities, 1987.

Generally, Rule 185 requires that case managers have at least a bachelor's degree in social work, special education or other related field, and one year of experience in the education of persons with mental retardation. However, persons with no experience in the field could be hired between the effective date of the rule and January 1987, as long as a plan for 20 or more hours of post-hire training was in place. Also, county boards may hire persons who have completed 40 hours of relevant education and training requirements to assist in providing most case management services, as long as these individuals are under the supervision of a case manager who meets the basic requirements.

## **Funding**

Case management services in Minnesota are paid for through county social service funding and through two federal Medicaid sources: Medicaid administrative funds and the Home- and Community-based Waiver. (Minnesota's Medicaid program is called Medical Assistance.) Expenditures for case management in Minnesota increased from approximately \$8.7 million in Fiscal Year 1986 to approximately \$19.5 million in Fiscal Year 1990. This 123 percent increase corresponded to a 19 percent growth in the number of persons served.

Counties paid approximately 55 percent (or \$10.8 million) of the \$19.5 million, while the state paid 24 percent and the federal government 21 percent. (See companion report.)

Funding of case management is complex and is described in more detail in Part 4.

## **Strengths and weaknesses**

Strengths and weaknesses of the current case management system in Minnesota were discussed in each of the interviews and focus groups, which are the primary sources of information for this section. Identified weaknesses reflect how involved parties say the case management system has been implemented. In some instances, this may not be entirely consistent with the intent of the policy makers. An emphasis on the weaknesses of the system reflects the purpose of this report — to identify alternatives to current practices that will improve case management in Minnesota.

### **Strengths**

- Case management attempts an individualized, holistic approach to client service. It identifies needs and attempts to match services to needs. It emphasizes planning and interagency communication and coordination and can provide linkages to generic services.
- Case management provides a vehicle for enhancing quality of life by assisting in the transition away from institutions and toward "normalization" and use of the "least restrictive alternatives."
- The case manager role provides the county with personal knowledge of its client

and provides the client with an important relationship and resource.

- Providers retain a role in service planning, but do not control it. In the past, providers were a primary source for planning and coordinating services. They had a financial incentive to use the existing services that they provided. Now case managers with no direct interest in the use of particular services are among the decision makers.
- Monitoring of services provides an important safeguard to a vulnerable population.
- County-based case management complements the county-based social services system in Minnesota. It ensures that casework is done at the local level. This is consistent with the theory supporting Minnesota's system — that planning and service delivery are most appropriately handled locally.

## **Weaknesses**

- **Interested parties expressed conflicting views on the value of case management:**

Opinions expressed in interviews and focus groups ranged from the belief that case management is the heart of a strong service system to the belief that case management is an unnecessary layer of bureaucracy. Perhaps the most commonly held view is that the concept is good but the implementation in Minnesota is weak.

Critics of the system expressed the following views:

Case management is overly paternalistic and controlling; it takes power away from clients and families (Department of Human Services official).

Parents do the case management anyway; paying for official case management services wastes resources (parent).

Case management is a "joke" and does not really happen (semi-independent living service provider).

The case management system is not responsive to clients (member of supported employment advisory committee).

Case managers must do so much petty work that it detracts from providing services (day program provider).

Case managers often do not know their clients (parent, day program provider, residential service providers).

The current case management system has "no bearing on reality" (Human Services official).

- **The quality of case management services varies widely:**

A common view is that the value of case management services depends in large part on the county or the individual case manager and that quality varies widely (clients, parents, residential service provider and Greater Minnesota focus group participants).

One participant in the special education focus group said it best: Case management is as strong as the individual case manager.

Interview and focus group participants often felt that the case management qualifications and training requirements of Rule 185 are insufficient. While some case managers were lauded for their creativity and expertise, others were perceived to need additional knowledge and training related to serving persons with developmental disabilities.

County compliance with Rule 185 requirements is low. For purposes of monitoring compliance, Human Services' rule-monitoring staff developed a definition of "compliance" less stringent than would be expected under the language of the rule. Even with this relaxed definition, they report that only two of the first 46 counties monitored were in compliance.

- **Individualized services are difficult for case managers to access:**

County case managers are often unable to locate and fund appropriate alternatives for their clients. A focus group for case managers ranked access and service availability issues as their most significant problem.

Minnesota has historically attempted to maximize federal financial participation in providing services to persons with developmental disabilities. Because federal dollars are most readily available for institutional care, Minnesota relies heavily on these settings. For example, a 1988 report by Human Services states, "Minnesota has consistently had the highest rate of utilization of ICF/MR services in the United States. In 1986 Minnesota's utilization rate was over two and one-half times the national average" (Human Services, 1988). Dollars, not needs, often determine what services people will receive.

The counties have strong financial incentives to use regional treatment centers and intermediate care facilities, regardless of their appropriateness for the individual. Although semi-independent living services in the community are less expensive in terms of total public dollars, they cost the county more. On average during FY 90, a county paid \$142 a month for a client in an intermediate care facility and a day program. If a person was in a semi-independent living arrangement, received a day program and had Minnesota Supplemental Aid to pay room and board, the cost to the county was approximately \$891.

Consequently, case managers report that too often their jobs do not involve the identification and development of appropriate services. Instead, their time and energy go into placing clients in intermediate care facilities for the mentally retarded or available openings in the Home- and Community-based Waiver program.

- **There are no formal cost containment mechanisms or strategies tied to case management:**

Annual public expenditures for services to Minnesotans with developmental disabilities increased from approximately \$408 million to approximately \$583 million from FY 86 through FY 90. On average over this period, developmental disabilities expenditures increased at a faster rate than either general inflation

or health care inflation, as measured by the Consumer Price Index. (See companion report for details.)

Cost containment mechanisms do exist for various components within the developmental disabilities service system. The state sets the rates for intermediate care facilities for the mentally retarded and regional treatment centers. Semi-independent living and family subsidy expenditures are limited by legislative appropriations. The Home- and Community-based Waiver places dollar limits on expenditures.

There is no formal case management mechanism, however, to limit growth or ensure cost-effective services at the individual client level. The following comments were made in interviews and focus groups regarding the case manager's role in cost containment:

Case managers are being out-advocated by the advocates; case managers should focus on obtaining the best services for the dollar (county official).

Case managers do not see the financial implications of their service plans and do not know how to get the best "bang for the buck" (member of Human Services advisory committee).

The case management process does not allow the prioritization of services based on needs and available resources (case manager).

The case management system needs more "real-world fiscal reality" (Human Services official).

Case managers are being expected to monitor huge budgets without standards or guidelines (county official).

Policy is being created by case managers in the front lines and it's driving system costs (county official).

Individuals are needed who are willing to take responsibility for allocating resources and making program adjustments (Human Services official).

- **Human Services, the counties, individual case managers and other stakeholders have not agreed on the basic purposes of case management:**

Interviews, focus groups and responses to draft versions of this report indicate strong differences of opinion regarding the fundamental mission of case management. The disagreement is over the question of whether cost containment is a part of the case management role.

This lack of agreement on the basic definition and purpose of case management contributes to role conflicts for case managers and confusion within the service delivery system.

- **Case managers face virtually unlimited human needs:**

A social service client's individual service plan is expected to indicate "how the services will assist the individual in attaining the highest level of independent functioning appropriate to the individual" (M.R. 9550.0090, Subp. 2.C).

An assumption was expressed in a number of interviews and focus groups that individuals with developmental disabilities are entitled to any and all services that will assist them in reaching their highest level of functioning. According to one legislator, goals become entitlements. Generally, this assumption of a broad entitlement was described as being unique to the area of developmental disabilities. The assumption is admirable, but has some negative ramifications.

Such high expectations can drive up service system costs. For example, some parents expressed the view that society is fully responsible for all costs associated with services to individuals with developmental disabilities. One parent described the responsibility of taxpayers as "full life support" for the person with developmental disabilities, including opportunities to go to college.

Case managers believe they must develop individual plans that identify all of a client's needs and wants regardless of whether services exist or can be afforded to address those needs and wants. Human Services officials presented conflicting views on whether this is true. Legislation passed in 1990 attempts to address this problem. Counties are no longer obligated to fund all "needs" identified in the individual service plan, but the burden is on the county to defend its action on the basis of fiscal limitations (M.S. 256B.092, Subd. 1c and 1d).

Despite the sizable investment and the high expectations, the need for services is not fully met. Parents and case managers reported that the demand for residential services greatly exceeds the supply. Waiting lists exist for a number of services, including semi-independent living (there were 510 people on waiting lists in FY 90) and family subsidy (192 on waiting lists).

- **The case management system becomes vulnerable to the pressures of more assertive families and advocates:**

Case managers report that planning and service development have become a matter of defensive legal strategies (minimizing risks of appeals and litigation) rather than of client-focused problem solving. Although Human Services reports only 23 formal case management appeals last year, case managers attending a focus group rated the litigiousness of the service system as their second most serious concern. They perceive themselves as having to develop service plans that deflect litigation rather than that provide services. Case managers who work in several service areas say this is not the case with planning for mental health or children's services. They expressed little confidence that the 1990 legislation will resolve the problem.

Similarly, a focus group of county social service directors and their representatives identified a system driven by courts, advocates and providers, rather than by client needs, as the single most serious problem. One consequence reported by these county officials is an inequitable distribution of resources among individuals with developmental disabilities. Clients who do not have assertive advocates



may end up on waiting lists while others receive costly, customized services.

County officials also suggested that counties do not have funds sufficient to cover all mandated services. When asked how they decided what to cover, one response was to assess the legal and political risks of not funding a mandate and make the safest choices. Another answer was to draw resources from weaker mandates such as mental health and child protection. Case managers and county officials from focus groups contend that this leads to an inequitable distribution of resources across the many service populations dependent on public resources.

- **Simplicity and common sense are often missing from the case management system:**

Twenty-seven Human Services rules or drafts of rules govern services to persons with developmental disabilities. The issue of over-regulation was raised in most focus groups and many interviews. Case management is intended to address problems inherent in a complex and fragmented service delivery system. Despite the good intentions, many believe it has further complicated the system.

Rule 185 is lengthy (20 pages) and detailed. Two participants in the Human Services advisory committee focus group expressed support for the rule. This, however, was a minority opinion. A sample of more typical opinions follows:

The requirements outweigh creativity and common sense (client advocate).

The rule is a "straightjacket" (Human Services official).

The rule's required process is "unmanageable" (member of special education advisory group).

Successful case managers ignore the rule (member of supported employment advisory group).

Rule 185 is too complicated to be useful (member of supported employment advisory group).

The detailed requirements make a case manager's job "terrible" (day program provider).

Case managers cannot do everything that Rule 185 requires (Greater Minnesota focus group participant).

The rule should not "micro-manage" the services provided by the counties (county official).

Paper-processing requirements of Rule 185 are excessive and have negative consequences for clients and case managers:

Paper compliance with the rule takes time away from service to clients (residential service provider).

Prescriptive rules adversely affect quality. Mounds of paperwork can obscure

real needs assessments. Clients can be "goaled and objectived to death." Some of the worst case managers are those who best follow the rules (case manager).

Paperwork, not quality, gets measured (semi-independent living services provider).

Over-regulation is cumbersome. The inordinate amount of paperwork required in the name of accountability actually results in a loss of accountability (county officials).

Case managers can spend their time rewriting providers' assessments and plans to conform to paperwork expectations. In the jargon of the field, IPPs must be turned into ISPs and IHPs (case manager).

The same level of case management may be provided to clients regardless of need.

As interpreted by counties, Rule 185 requires the same level of case management for all persons with developmental disabilities. Case managers are expected to follow the same process of developing, implementing and monitoring a detailed plan of care for all clients, whether they need a few hours of respite care in their family home or intensive, customized services in a community setting.

However, Human Services officials indicate that the rule is intended to allow some flexibility in tailoring the level of case management to the needs of clients and that their informal interpretations to counties are consistent with that view.

Several focus groups urged changes in regulations, including Rule 185:

County officials recommended scrapping Rule 185 and replacing it with outcome-based goals.

Parents urged more flexibility in the rules.

The Greater Minnesota focus group recommended a reduction of duplication and over-regulation. They said Rule 185 should be rewritten or enforced and that it must be realistic.

Semi-independent living service providers said there is too much paperwork and over-regulation and that Rule 185 should be implemented or eliminated.

The top-ranked recommendation from the case managers focus group involved simplifying and standardizing the individual service plan. Their third highest recommendation was reducing the bureaucracy for case managers.

- **Job satisfaction and morale for case managers is low:**

Interviews and focus groups indicated that case management is often seen as a low-prestige administrative job in a county work culture that values social work. Participants in four focus groups reported that high turnover in the role had adversely affected clients (day program provider, residential service provider, Greater Minnesota participant and member of supported employment advisory

committee). Clients in one county were reported to have had up to five case managers in one year.

Case managers themselves commented on tremendous stress levels, an inability to meet state requirements, overwhelming paperwork, fear of being sued, not being able to find appropriate services including crisis care, conflicting rules and regulations, lack of support and direction from Human Services, inadequate training, role conflicts and a sense of powerlessness.

- **Role conflicts for case managers have not been resolved:**

One case manager noted that success in the role requires being a magician, a juggler and a politician.

A conflict of interest is inherent in the case management role. Even without a formal cost containment mechanism, case managers report feeling pressure to conserve county and other public resources. At the same time, they are expected to advocate the needs of their clients. Pure advocacy suggests an unconditional support for the client's interests as defined by the client. Obviously, an individual client's interests and the broader system interests may be in conflict.

Case managers report that their role is further complicated when they are the legal guardian for the client. For example, the supervisory role of a guardian may conflict with an advocacy role by limiting client choice and decision making.

Other duties of a guardian, such as approving the use of state wards as research subjects or advocating for scarce resources, may pit client-based goals against system-based goals. One case manager said that she feels she has to second-guess a physician when asked to approve psychotropic drugs in her guardian role, and that she isn't qualified to do so. This conflict between the case manager and the guardian role was mentioned as a concern in several interviews and five focus groups (case managers, parents, day program providers, residential services providers and Greater Minnesota issues group). Human Services has advised the counties that state law prohibits assignment of case management and guardianship duties to the same county employee.

Participants in three focus groups indicated that it can be difficult to understand the respective roles and authority of case managers and Qualified Mental Retardation Professionals (day program providers, residential service providers and Human Services advisory committee).

Federal regulations require that certain planning, coordination and monitoring functions be provided for residents of intermediate care facilities for the mentally retarded by Qualified Mental Retardation Professionals employed by the residential facility. Although the federal and state governments have a written agreement regarding the respective roles of county case managers and Qualified Mental Retardation Professionals, roles and authority are not always clear to the affected employees. One case manager said that the relationship with the individual intermediate care facility for the mentally retarded dictates who is really in charge.

Three focus groups involving providers claimed that the providers' staffs are doing much of the work associated with case management. For example, a semi-

independent living service provider indicated that the individual service plan is prepared by the service staff and simply signed off by the case manager.

Two focus groups of residential providers also raised role and authority issues involving the case manager and the interdisciplinary team.

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Part 4.

CASE MANAGEMENT  
ALTERNATIVES

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# CASE MANAGEMENT ALTERNATIVES

**M**innesota relies on a county-based system of case management in which all persons seeking developmental disability services are required to have a case manager. Case management's primary goal is to ensure access to services by assessing client needs and then developing and implementing a service plan to meet these needs. Case management in Minnesota is funded through Community Social Services funds, Medicaid administrative monies, and the Home- and Community-based Waiver available under Medicaid.

The state could pursue numerous options in modifying its case management system. This part describes major options as they relate to the following questions:

**Who should receive case management?**

**Who should provide case management?**

**Who should fund case management?**

**To what degree should case management be regulated?**

The project team's proposed answers to these questions are in the recommendations at the end of this report.

## **Who should receive case management?**

State policies and federal funding sources differ on eligibility for case management. Medicaid-funded case management is available only to persons who meet the income eligibility requirements for Medicaid. Under the Home- and Community-based Waiver (which is Medicaid-funded), case management generally is a service only for persons who are at risk of being institutionalized, or who are in an institution and being relocated to the community.

In many states, such as Arizona, Michigan and Minnesota, any person who wants to receive developmental disability services is eligible for, and required to receive, case management. In other states, such as Vermont, families who wish to receive only respite care do not receive case management. In New Hampshire, case management is not provided to individuals who have a family member who is able and willing to provide case management. Other states also vary the level of case management provided to an individual client, based on individual need, as shown in Table 2.

## **Who should provide case management?**

State policies vary considerably regarding the types of agencies and individuals that deliver case management services. Major issues that are pivotal in understanding and selecting from these options include:

- **whether case management is delivered as a freestanding service,**
- **whether case management is delivered through the public or private sector,**
- **whether case management functions are divided between agencies, and**
- **whether parents play a role in the case management process.**

### **Whether case management is delivered as a freestanding service**

Case management agencies may be freestanding, meaning that the agency providing the case management does not also provide or fund other developmental disability services. Case management agencies might also *provide or fund* other developmental disability services.

**Freestanding model:** Freestanding case management agencies provide case management services, and do not fund or provide other services. From a client-based perspective, the advantage of this type of system is that case managers are able to focus on the needs of the clients, without worrying about a service plan's financial impact on an organization

This freedom from worrying about financial impact is also a major disadvantage, if it results in increased costs. Also, "an independent case management system cannot exist without an administrative structure, but such structure would, in addition to being costly to implement, potentially create another layer of bureaucracy" (State of South Carolina, 1986).

**Case management agencies that also provide other developmental disability services:** Case management providers that also provide other services have been the norm historically in Minnesota and in other states. Providers of residential care, for example, were a source of information, referral and planning services to prospective and admitted residents before other case management systems were developed. Today, the federal government expects providers in intermediate care facilities for the mentally retarded to provide certain planning, coordination and monitoring functions through Qualified Mental Retardation Professionals.

One advantage to using providers of other services to perform case management is that existing personnel can be used, obviating the need to create many new positions and new administrative structures. Also, providers are often closest to the clients, knowing in detail client needs and preferences.

However, service providers who also provide case management may have incentives to channel clients into their own services or may not be objective in monitoring the quality of their own services. Also, "when an agency has limited resources and carries both case coordinating functions and direct service functions, the direct service demand for time and resources prevails over the needs of the case management program (daily routine replaces planning)" (State of South Carolina, 1986).

**Case management agencies that also fund other services:** In many states, such as Minnesota, the agency that provides case management is also the agency that provides partial or complete funding for other developmental disability services (for example, state, regional or county government bodies).

**Table 2. Examples of methods used by states to provide differing levels of case management services**

<b>State</b>	<b>Method</b>
<b>Ohio</b>	Case managers monitor only "open active" cases - those in which services have been provided within a 90-day period.
<b>Connecticut</b>	Clients have an overall plan of service, similar in detail to Minnesota's individual service plan (for example, it includes goals, objectives and strategies) or a short follow-along plan that simply outlines how services are to be provided. Follow-along plans are for clients who live independently or with their families, and who receive such services as occasional respite care, recreation or transportation.
<b>Massachusetts</b>	No individual service plan is required for any service such as respite care if it is not likely to continue for more than 30 continuous days or for more than 60 days during a 12-month period.
<b>Colorado</b>	The Qualified Mental Retardation Professional completes the individual habilitation plan for clients of intermediate care facilities for the mentally retarded. The case manager in those cases ensures the client due process, reviews the individual habilitation plan, provides information to the family, and participates in the discharge planning process.

**Source:** Interviews of state representatives, and a review of related state documents, Fall 1990.

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It is characteristic of this option that the agency, because it funds services, has incentives to operate efficient case management systems and to promote the greater use of cost-effective service alternatives. This is a significant advantage when system-oriented goals are pursued.

On the other hand, funding concerns may conflict with client-based goals. Funding agencies may have incentives to refer clients to settings that are less expensive for that agency, whether or not that type of care is most appropriate for the client or less expensive overall for taxpayers. County-administered case management agencies may channel clients to alternatives such as intermediate care facilities for the mentally retarded, where the county pays only a minimal share of the cost. State-administered case management agencies may steer clients toward services that are funded by federal and county governments.



## **Whether case management is delivered through the public or private sector**

Many states have chosen to deliver case management through the public sector. In Minnesota, services are delivered through the counties, while Connecticut and Rhode Island deliver services through the state, and Michigan and Maine have regional systems. A potential advantage to keeping the delivery of case management in the public sector is that it can allow for greater public control over service delivery and associated costs.

Also, public systems are often perceived as more objective, client-based systems. In the statement of need and reasonableness for Rule 185, for example, counties are exempted from the provision that case managers cannot also provide direct services, with the following rationale: "It is reasonable to exempt the county board and other public agencies from the requirement as long as some safeguards are in place because the county board or public agency does not have the same level of economic interest in the specific services as a private provider does."

Although public systems may be more objective than private-sector providers with a direct financial interest in referring to their own services, public agencies are still subject to conflicts of interest. As mentioned earlier, for example, counties have financial incentives and disincentives to use particular services.

When a state decides to keep case management within the public sector, the question arises whether case management should be delivered through state, regional, county or other local agencies. More local control allows for greater flexibility in meeting local needs, while statewide systems can be used to ensure more uniform access to services across the state.

One issue that must be considered in any assignment of case manager duties is the recipient's freedom of choice. As a rule, recipients of Medicaid-funded services are entitled to select their provider from a pool of qualified providers. Limited exceptions to the rule affect case management; they are discussed in more detail in the section on funding options.

Private-sector involvement and freedom of choice for consumers may also increase quality and cost-effectiveness through competition.

A barrier to using the private sector is the possibility that government entities may expect the system to become more complex and less controllable because a more diverse pool of providers is involved.

## **Whether case management functions are divided between agencies**

Minnesota is typical of many states in that all or most of the functions usually considered to be case management are provided by the same agency — the county social services department.

However, for individuals in intermediate care facilities for the mentally retarded, federal regulations require that a Qualified Mental Retardation Professional, employed by the facility, perform certain planning, coordinating and monitoring functions. Federal funds cannot be used to pay for any county employee activities

that would be seen by federal officials as duplicating duties of the Qualified Mental Retardation Professionals. This raises federal funding complications that are discussed in the funding section and later in the case management models. The regulation also results in role conflicts between county case managers and facility staff because the duties and authority of each are not always understood.

In some states, case management administrative and service functions are split between two agencies. North Dakota, for example, uses what it calls external and internal case management. External case management, done by the public sector, includes the administrative functions, such as brokering services, authorizing services, ensuring access and conducting an annual review of the service plan. Internal case management, conducted by private-sector providers, involves the service functions, such as developing a service plan, making day-to-day contacts with the clients, and meeting with parents (the appendix has more details).

A similar splitting of functions has been proposed for Massachusetts, as case management relates to children with developmental disabilities (Healy, 1990).

A major reason to split functions in this way is to address conflict-of-interest issues. Advocacy roles and gatekeeping functions can be separated. External case managers can be more objective than internal case managers in monitoring quality, while the internal case managers' expertise related to the clients can be applied. Splitting case management functions may also enhance a state's ability to obtain federal reimbursement for case management services (discussed in the following section on funding options, and in the second case management model in Part 5).

### **Whether parents play a role in the case management process**

Informally and historically, parents have served as the case managers for their children, assessing needs and arranging for services. As the number of formal case management systems has grown, parents have often become part of an interdisciplinary team consisting of the parents, the client, a public case manager and other professionals who work with the client.

Some states are recreating a broader role for parents, formally making the parents the child's case manager. In this type of "family-centered" case management, it is assumed that "children already have a 'service coordinator,' their parents .... The goal of case management is to enable and empower families to negotiate and receive the services they require for themselves and their children to maintain them at home and in their communities and eventually to become independent of the helping system" (Healy, 1990).

One advantage to using parents as case managers is that they are often in the best position to know their child's needs, abilities and preferences. Also, parents as case managers provide a degree of normalization to the client - parents of children without developmental disabilities are "case managers" for their children, deciding what the children want and need.

A major disadvantage to using parents as case managers is that parents may not have the expertise of professionals in evaluating needs, arranging services and monitoring care. In some cases, parents may not have sufficient objectivity or

access to resources to meet the legitimate needs of both the parents and the child. Parents, for instance, could choose to meet their own needs for respite care rather than their child's need for a different service.

Parent-as-case-manager projects have met with mixed success. In Maine, a family-based program stimulated little interest from the parents. Several pilot projects in Minnesota have achieved positive outcomes with small groups of motivated parents.

A "Consumer Case Manager Project" was developed by the Association for Retarded Citizens - Suburban. It covered a three-year period and included two study groups - one of parents and another of persons with developmental disabilities. Participants received training and a stipend of \$40 per month for their involvement. They did not assume responsibility for county case management functions, but worked in partnership with the formal case managers. Parents expressed satisfaction with the knowledge, empowerment and support they received. Parents were split over whether they should be paid for their case management activities (Lang and Perryman, 1990).

The "Dakota County Voucher Project" involved 12 families that had been in the service system. Cash (not vouchers) was given to each family, based on costs of services they had used in the past. All the families are entering the second year of the project and none have chosen to return to the conventional service system.

Families kept journals to document their use of the funds. Most expenditures were on items that would not normally be allowed by Dakota County or the State Family Subsidy program. The most common expenditure (31 percent of the total allocation) was for respite care with unlicensed providers. Because unlicensed providers cost less and have fewer restrictions (for instance, no minimum number of hours per job and no restriction on caring for siblings of the child with the disability), parents had more flexibility and obtained more respite care per dollar. Nineteen percent of the funds were spent on home modifications or housecleaning, and 9 percent on recreational activities.

Families are satisfied with the project because of the enhanced flexibility and empowerment and the ability to stretch respite dollars. Concerns regarding this approach from the public perspective include county staff time needed to review parent expenditures, county liability when parents hire unlicensed providers and the possibility of public and political criticism of the unconventional expenditures (Dakota County, 1990).

## Who should fund case management?

Case management in Minnesota is financed with Medicaid administrative funds, the Home- and Community-based Waiver under Medicaid, and county social services funding.

Possible Medicaid funding options, not currently used in Minnesota specifically for persons with development disabilities, include targeted case management, freedom-of-choice waivers, and Section 624 of the Omnibus Reconciliation Act of 1990.

Funding sources under Medicaid vary according to whether case management is considered to be an administrative activity or a Medicaid service. Administrative funds pay for case management that is part of overall Medicaid administrative functions, while targeted case management, the various waivers and Section 624 are intended to fund case management as a service.

A state may use several Medicaid funding options for case management at the same time. Payment for case management under one program, however, must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose (HCFA, 1988).

### Medicaid Administrative Funds

Case management activities funded through administrative funds must be related to *Medicaid-funded* services, with the goal of ensuring that provided services are medically necessary. Types of activities that could be funded in this way include conducting Medicaid eligibility determinations, completing diagnostic assessments, authorizing services, service coordination, monitoring/utilization review, and follow-up.

Reimbursement for administrative funds is secured through the Social Services Random Moment Time Study. Federal Medicaid dollars are allocated based on random calls to county staff to ascertain what tasks employees are doing at the time called. Administrative costs may be reimbursed at a 50 percent matching rate. In Minnesota, the counties contribute the other half. Under federal rules, however, it doesn't have to be this way - the 50 percent non-federal share could be split between the counties and the state, or paid in full by the state.

One advantage of funding case management through administrative funds is the relatively simple paperwork. To document costs, the state does not need service-specific or client-specific information, which is needed when case management is funded as a service.

Another benefit of using administrative funds is that free choice of vendor is clearly not an issue. Because reimbursable activities are administrative functions rather than services, it would not be reasonable for the client to choose among providers.

One problem with this source of funding is that, while Minnesota could in theory collect 50 percent of the administrative costs from the federal Medicaid program, it is reportedly collecting much less. A large part of the problem appears to be in

the way the random time study is conducted. The process may result in an under-representation of the amount of time counties are spending on case management activities. Reliable data regarding actual reimbursement for case management could not be obtained for this study's companion analysis of public expenditures.

Another limitation to using administrative funds for case management is that it must pertain only to helping an individual access *Medicaid-funded* care.

A third concern with reliance on administrative funding for case management is that the Health Care Financing Administration, the federal agency that administers Medicaid, may become stricter in its regulation of the use of administrative funds for case management, because of concerns that some states are using administrative funds for nonadministrative purposes.

### **Community social services funding**

Community social services funding pays for case management that is not reimbursed through the Home- and Community-based Waiver or through Medical Assistance administrative funds. Community social service funds are delivered via Title XX and Community Social Service Act block grants to counties. They allow counties, within broad guidelines, to provide a mix of social services that meet local needs and preferences.

Case management is just one of many services that can be funded through community social service funds, and persons with developmental disabilities are only one of eight targeted populations to be served with these monies.

In 1990, federal funds provided 21 percent of community social service funding. Minnesota provided 27 percent, counties 50 percent, and other sources such as private contributions approximately 2 percent (Human Services, 1990).

An advantage to using county social service funds to pay for case management is that these monies are tied to relatively few federal restrictions. Case management funded in this way, for example, can be used to serve all persons with developmental disabilities, not just persons who are at risk of institutional placement, or who meet low-income guidelines. A major disadvantage is that county social service funds are used to serve a very wide variety of populations and needs, depending on individual county priorities. Funds for case management and related services are therefore affected by the needs of other populations in the county, and by county philosophy toward developmental disability service funding.

This problem is exacerbated by the fact that Minnesota has established levy limits that restrict how much money counties can raise for these funds. Also, county representatives in focus groups reported having to cut other social service spending for persons with developmental disabilities and other vulnerable populations, because case management is a mandated service.

### **Home- and Community-based Waivers**

Home- and Community-based Waivers were authorized by Congress in Section 2176 of the Omnibus Budget Reconciliation Act of 1981. These waivers allow Medicaid to

cover home- and community-based services to persons who would otherwise be living in an institutional setting. Waivers were originally developed to provide community-based alternatives to nursing home care for low-income elderly persons. "The fact that services to persons with developmental disability now dominate this program (nationally) was neither planned nor anticipated by Congress in 1981" (NASMPD, 1989).

The Home- and Community-based Waiver for persons with developmental disabilities is expected to "promote community living and integration in the least restrictive environment consistent with individual needs" and result in "reduction of spiraling long-term care expenditures and the simultaneous increase in cost-effective alternatives" (Minnesota Department of Human Services, 1987).

Case management under the waiver is "the service responsible for locating, coordinating, and monitoring social, habilitative, medical and other services, both on a formal and informal basis, to meet the needs of eligible persons and their families" (Minnesota Department of Human Services).

Case management and other home- and community-based services can be provided under the waiver to Medical Assistance-eligible persons with mental retardation or a related condition who are currently receiving the level of care provided in an intermediate care facility for the mentally retarded and for whom home- and community-based services are appropriate; or who, but for the waiver, would require the level of care provided in an intermediate care facility.

Federal waivers are authorized for specific periods of time. The current waiver is for July 1987 through June 1992. Minnesota will need federal reauthorization to continue use of federal money for the program beyond then.

One advantage associated with the Home- and Community-based Waiver is that case management funded under the waiver can be used for coordinating and monitoring a wide variety of services. Second, the waiver is designed to control the overall cost of services. County limits are placed on the number of persons who can be served by the waiver. Also, states must demonstrate that the average per capita cost for waived services does not exceed the cost that would have been incurred if the recipients were in Medicaid-funded institutions.

One disadvantage to using the waiver and other options where case management is a service is that billing information must be client- and service-specific, entailing more paperwork than the administrative funding option.

Other concerns or limitations include:

Freedom-of-choice issues may have to be addressed when the waiver is renewed, if case management is continued as a federally reimbursed service. If county affiliation is not seen as a legitimate qualification standard for case managers, the pool of qualified case management providers may have to be broadened.

An additional complication is that the Health Care Financing Administration is requiring states to develop user fees and third-party liability billing for case management before federal dollars can be used to pay for it. Here, the theory is

that public resources should not be expected to pay for a service that is free. One federal official recommended the development of a sliding fee scale, with billing to families and insurance companies.

The waiver is designed to serve only persons at risk of institutionalization (diverting persons from entering an intermediate care facility, for example, or allowing them to leave the facility for a community placement).

While cost control is a laudable goal for waived services, it may also work to restrict access to services. Access to waived services is limited to a set number of individuals in a given county.

In general, there is some instability with this source, because the waiver has to be renewed every five years.

### **Other Medicaid options not currently used in Minnesota**

**Targeted case management:** Targeted case management, authorized by the Consolidated Omnibus Budget Reconciliation Act of 1985, was signed into law as Section 1915g of the Social Security Act. The act allows states to amend their state Medicaid plans to include the coverage of case management, which was previously excluded.

The act's provisions related to targeted case management also allow states to waive the normal Medicaid requirement that Medicaid services be available in all areas of the state, and that services be available in equal amount, duration and scope to all Medicaid beneficiaries. Thus, case management services can be targeted to population subgroups such as persons with mental illness or mental retardation, or persons living in certain parts of the state.

As defined in the act, case management means "services which will assist individuals eligible under the plan in gaining access to needed medical, social, education and other services." It specifies that the intent of targeted case management is "to allow case management to be provided as an additional service, It is not the Committee's intent that the States use case management solely to reduce program costs."

As of October 1990, four of the six states in this Health Care Financing Administration region have or have applied for targeted case management (Wisconsin, Michigan, Ohio and Indiana). Minnesota and Illinois have not pursued this option for persons with developmental disabilities (HCFA, 1990). Minnesota does have targeted case management for persons who have a serious, persistent mental illness-

There are several advantages to targeted case management:

Targeted case management could increase the federal contribution and decrease the county contribution toward the costs of case management.

As a state plan amendment, targeted case management doesn't have to be renewed every five years.

Services can be directed to persons with developmental disabilities, and services do not have to be offered on a statewide basis. The population can be generally defined (for example, all persons with a developmental disability) rather than restricted to persons at risk of institutionalization.

Case management is not limited to coordinating and monitoring Medical Assistance services.

Freedom to choose one's provider is not required when the population receiving targeted case management is made up of persons with developmental disabilities or chronic mental illness.

Targeted case management focuses on client advocacy, and may therefore increase access to needed or desired services.

One disadvantage of targeted case management from the state fiscal perspective is that it would require the normal state match under Medicaid of about 43 percent (and county match of about 5 percent). This compares with no state match under the administrative funding option.

Also, targeted case management does not necessarily focus on cost containment. Because it emphasizes advocacy and assisting clients in accessing services, overall system costs could increase.

Additionally, targeted case management would provide counties with federal and state funds to comply more completely with Rule 185. This could increase case management costs without ensuring an equivalent increase in quality. (The state could limit costs of targeted case management by limiting the number of hours or service units available, but this would not resolve the problem of overall system costs.)

Another problem with the targeted case management option is that case management is a service, entailing more paperwork for reimbursement than when case management is funded as an administrative cost. Federal sources indicate that recordkeeping expectations will be high and that monitoring will be especially strict if the same agency is providing both the administrative and service components of case management.

Federal requirements pose additional disadvantages for case management funded as targeted case management. Targeted case management probably cannot be used to pay for county case management services for individuals in intermediate care facilities for the mentally retarded. When California submitted a state plan amendment seeking targeted case management funds for intermediate care facility residents, it was denied by the Health Care Financing Administration. The reason cited was that "[i]nclusion of case management services provided to residents of intermediate care facilities for the mentally retarded would constitute duplicate Medicaid payment as the Medicaid facility rate should include the cost of case management services" (Macomber, 1990). An exception can be made for a limited period of time for discharge planning.

Further, targeted case management would appear to necessitate the development of user fees (see related discussion concerning disadvantages of the Home- and Community-based Waiver).



**Freedom-of-choice waiver:** Case management may also be provided through a freedom-of-choice waiver (1915b). The purpose of this waiver is to allow states to establish a primary care case management system. Primary care generally refers to acute care services such as physician and hospital care.

Case management in this context serves as a gatekeeping function to ensure that clients receive appropriate services within the network of primary care providers. In some cases, however, states are using this waiver for persons with mental health problems. No states have used the waiver to specifically serve the developmentally disabled population, although nothing would preclude a state from doing so (HCFA, 1990). Minnesota currently has a 1915b waiver for persons with substance abuse problems.

**Section 624 of the Omnibus Budget Reconciliation Act of 1990: Community-supported Living Arrangement Services.** Although not designed specifically to provide case management services, Section 624 of the Omnibus Budget Reconciliation Act of 1990 establishes "community supported living arrangement services as a new optional service that (four to eight) states could add to their Medicaid plans on a limited basis for the first five years of the program" (Congressional Record, 1990). Services can be provided to all persons with developmental disabilities, not only to those who are at risk of institutional care.

Community-supported living arrangement services are "designed to assist an individual in activities of daily living necessary to permit such individual to live in an integrated environment" (Congressional Record, 1990). Services may include personal assistance, training and habilitation services, adaptive equipment, and other non-excluded services such as case management. Excluded services are room and board and pre-vocational, vocational and supported employment services.

A disadvantage to pursuing the Section 624 option is that the amount of money likely to be available for case management services is low — a total of \$100 million has been allocated to allow four to eight states to deliver a variety of home- and community-based services over a five-year period. Also, states may wish to use Section 624 monies to fund other home- and community-based services (for example, respite care) that are particularly difficult to fund under current programs.

## Summary

Minnesota currently uses Medicaid administrative funds, Home- and Community-based Waiver monies, and county social services funding to pay for case management.

Use of Medicaid administrative funds reduces the state's costs and avoids the freedom-of-choice issue, but relatively little money has been obtained through the Social Services Random Moment Time Study mechanism.

County social service funds have the advantage of being free of federal restrictions. The major disadvantages of using these funds are the fiscal burden on counties and the possibility of unequal services across counties because they are based on available funding and commitment.

Advantages to using the Home- and Community-based Waiver include the fact that the necessary administrative and political supports are already in place for the waiver, and the waiver as a whole is designed to contain costs. Federal issues, however, may need to be clarified and resolved before the waiver renewal application is developed.

Other options available to Minnesota include the freedom-of-choice waiver, Section 624 funds and targeted case management.

An advantage to using the targeted case management option is that it does not require clients to be at risk of institutionalization. Also, targeted case management services for persons with developmental disabilities are not required to meet freedom-of-choice requirements. But user fees and inability to fund case management services to persons in intermediate care facilities for the mentally retarded may be problems. Another major disadvantage is that the availability of federal funds for an advocacy type of case management has the potential to greatly increase costs without a proportional increase in the quality of services.

Freedom-of-choice waivers and Section 624 funds are additional, relatively limited sources of case management funding.

## **To what degree should case management be regulated by the state?**

Tremendous variation exists among states in the degree to which case management services are regulated. States such as Minnesota and Colorado have lengthy rules that detail how case management service plans are to be developed, implemented and monitored. At the other end of the spectrum, states such as Rhode Island have no case management rules or regulations. In between these extremes, a state may establish general guidelines for the provision of case management services.

Interviews with representatives from various states indicated that one reason states may wish to regulate is to ensure uniformity across the state. States may also establish regulations in order to set standards of quality for case management, and to hold case management agencies accountable for these standards. A state may be particularly apt to highly regulate when the state is funding a large proportion of case management or developmental disability services. Federal regulations and requirements of the state's Administrative Procedure Act also drive the prescriptiveness of Minnesota's rules.

Interview responses also indicated that states may choose *not* to highly regulate case management, to allow for flexibility in meeting individual needs. One individual stated that her state's case management statutes are intentionally general to allow for interpretation. In another state, a project to write case management standards was dropped because the variation in the capacity of clients and their families to meet their own needs made writing the standards very difficult.

Alternatives in the degree to which Minnesota might regulate county activities have been described by Michael Scandrett of the Minnesota Senate research staff in a

recent draft discussion paper on state mandates (Scandrett, 1990). Scandrett describes these alternatives as part of a continuum ranging from no state control to total state control. This continuum is applicable to the state's role in regulating case management. Some of the points in the continuum, listed roughly in order of increasing state control, include:

**Monitoring:** The state monitors county programs but has no enforcement authority.

**Statewide planning and coordination:** The state conducts statewide planning, coordinates programs and services across the state, and imposes some limited requirements upon counties.

**County option:** The state establishes uniform statewide program standards and requirements, but counties may choose not to participate.

**Reactive intervention:** There are no significant statewide requirements, but the state monitors and evaluates county programs and takes action when significant problems occur.

**Cooperative negotiation:** Each county is free to design its own program, subject to final approval by the state.

**Minimum standards:** Every county is required to provide the program and meet state-established minimum standards.

**High state standards:** The state imposes significant uniform statewide program standards and requirements that go beyond minimum standards.

**State delivery:** The state, instead of the counties, delivers the service or administers the program.

According to the discussion paper, a state may have many different reasons to be more or less controlling of county policies. All of the following are relevant to the provision of case management.

In general, greater state control may be called for when;

the federal government imposes specific mandates and requirements,

funding is insufficient to meet needs (so that the state may have to set priorities),

clients are vulnerable (that is, they face significant health or safety risks, or are unable to complain when services are not available),

a significant number of counties don't want to be involved, or uniformity in service delivery is important.

Greater county control, on the other hand, may be warranted when:

there is substantial variation by county in the need for services, effectiveness of different strategies, and local service priorities,

knowledgeable people don't agree that one single approach is most effective,

funding is insufficient (so that more creativity and innovation are needed, less money is available for administrative activities, and counties may have to set priorities),

effective methods of measuring and evaluating outcomes and program quality exist, or

counties have successfully delivered services in the past.

Minnesota's case management policies fit within the continuum as a state with high state standards, which may help explain why counties may be unable to approach full compliance with mandates, and why an adversarial relationship exists between the state and many counties on case management issues. Generally, the discussion piece suggests that the state allow counties more discretion in developing and implementing policies, and mandate only when there are no better alternatives for ensuring compliance.

If these suggestions were applied to case management, Rule 185 would become less prescriptive, counties would be allowed greater freedom in designing and implementing case management services, and outcome measures for evaluating quality would be developed. Others have suggested, however, that the state has a right and a responsibility to highly regulate case management services because of the vulnerability of the population, because the state funds a large portion of all developmental disability services and because qualifications and training of case managers vary.

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## **Part 5.**

# **CASE MANAGEMENT MODELS**

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# **MODEL I: Streamlining and implementing Rule 185**

## **Introduction**

This model would be most appropriate if Minnesota's case management system was working well and needed only some incremental changes. Improvements to the system focus on modifying Rule 185 to give counties more discretion in developing and implementing case management services, and streamlining the rule to reduce paperwork, to reduce duplicative efforts, and to limit the number of clients required to have a case manager.

## **Rationale**

The current case management system has strengths worth preserving. It focuses on individualized planning, provides a range of services from intake to long-term monitoring, and gives clients a single point of access for obtaining services. Rule 185 and the county-based system are well established. This model builds on the strengths and structure of the current system.

Despite its strengths, Rule 185 is overly prescriptive. It details how and when case managers are to conduct assessments, develop individual service plans and monitor client services. As described by case managers and other stakeholders in Part 3, many parts of the rule require substantial paperwork and may result in duplicative or unwarranted activities. Counties have little opportunity to develop innovative, more rational approaches to case management and service delivery because of Rule 185. Within reasonable levels of accountability, more county discretion is needed to allow for innovation, and to allow counties to tailor programs to local needs.

## **Description**

Rule 185 should be modified to reduce unnecessary paperwork and to allow case managers to concentrate their efforts on meeting real client needs. Examples of changes to meet this goal include:

Reduce caseloads by not requiring case management for persons who need a minimal amount of care, such as families requesting only respite care.

Remove the requirement to write summaries of already existing documents. Specify only that these documents be read and that their information forms a basis for identifying client needs.

Eliminate what are possibly redundant assessments and service plans. For example, allow acceptance of a diagnosis completed earlier than 35 working days prior to receipt of the service application. Also, allow attachment of the annual review document in lieu of modification of the service plan.

Rule 185 should also be changed to allow county case managers more discretion in planning and implementing case management services. For example, allow case managers discretion in requiring reassessments, determining the need for annual physical examinations, and substituting other plans such as the individual family service plan for the individual service plan.

Once Rule 185 is adequately modified, counties would be expected to comply. Human Services should disseminate information on the best practices of counties that develop successful models and innovations within the parameters of the revised rule.

## **Advantages and disadvantages**

Modification of Rule 185 is a conservative approach which may be less controversial, and structurally simpler to implement, than other models discussed in this report.

This model also acknowledges and retains several important strengths of the current case management system, such as an emphasis on individualized planning and a single point of access.

Importantly, this model simplifies the case management process by addressing one of the biggest problems with the current system — an overemphasis on what is often unnecessary paperwork. Further, this model allows case managers to focus on clients who most need their assistance by allowing certain clients to be exempted from the case management process, such as persons requesting only respite care. This can result in better service for the clients, and more job satisfaction for the case manager.

A primary disadvantage of this model, however, is that it does not include measures for containing the costs of case management, or the costs of developmental disability services as a whole.

In addition, this model does not attempt to solve problems relating to conflict of interest and role confusion for case managers. Under this model, for example, case managers could still serve both as a client's advocate and as the county's financial gatekeeper. Further, this model does not address issues relating to recipient freedom of choice and the development of user fees.

Another problem with this model is that previous attempts to modify Rule 185 have resulted in even more burdensome requirements. Often it is politically difficult to dismantle any degree of regulation once it has been established.

## **Conclusion**

The major advantages to this model are that it simplifies Rule 185, reduces unnecessary paperwork, exempts clients who don't need case management, and gives more control to counties. All of these steps are important for improving the current system, and should be implemented.

Given the high and rising costs of these services, however, this model of streamlining and implementing Rule 185 should be pursued only in conjunction with a model for containing system costs.

# MODEL II: Split functions

## Introduction

This model separates the administrative and service functions of case management, with administrative functions conducted by county staff and service functions by contracted case managers, who could be employed by public or private organizations.

## Rationale

A primary reason for splitting case management services in this way is to clearly separate and document the different types of services provided by case managers, and then obtain funding from appropriate sources. Medicaid administrative funds would be used to pay for the administrative services.

Targeted case management would fund the service functions, and case management would be removed from the Home- and Community-based Waiver so that the two programs would not duplicate one another. Funding case management through targeted case management instead of the waiver would also mean that freedom-of-choice concerns now threatening waiver renewal would no longer be an issue.

This model also provides a private-sector role in case management, to increase competition, client choice and cost-effectiveness of case management services.

## Description

*Administrative functions* to be performed by county staff would include activities related to the "proper and efficient" operation of the State Medicaid Plan. They include the following activities, as they relate to accessing and providing *Medicaid* services:

eligibility determination	prior authorization
diagnostic assessments	utilization review
contract development	

Administrative functions would be financed through Medical Assistance administrative funds. As necessary, staff would be trained, and the Social Services Random Moment Time Study would be modified, so that case management administrative activities would be accurately reflected in the survey, and subsequently reimbursed as appropriate.

*Service functions*, to be funded as targeted case management, include activities that assist individuals in "gaining access to needed medical, social, educational and other services." Service functions could be delivered by the county or in freestanding private case management agencies.

The targeted group would be all persons who have a developmental disability and are Medicaid-eligible. Service functions are distinguished from administrative



functions in that they go beyond activities related only to Medical Assistance. Examples of service functions are:

- developing service plans
- coordinating services
- monitoring services

Targeted case management is usually used to fund case management for a set of clients who cannot receive case management funding from other federal sources. For example, in a state that has a Home- and Community-based Waiver to fund case management for persons who are at risk of institutional care, targeted case management may be used to fund case management for persons ineligible for the waiver. In the split functions model, however, Medicaid administrative funds and targeted case management (service) funds could be used to fund two different types of case management functions (administrative and service) for the same client. This model would therefore require negotiation with the Health Care Financing Administration staff to detail how service and administrative functions are specifically defined.

## **Advantages and disadvantages**

Splitting administrative and service functions could be advantageous to the state in several ways. It would allow the state and counties to clearly define and track the activities conducted by case management personnel. This could reduce duplication of effort, set the stage for better planning for various case management services and personnel, and clarify tasks for federal reimbursement purposes.

Also, splitting administrative and nonadministrative functions could address role conflicts when a case manager is both an advocate and an administrator of funds. In this model, the county could be responsible for administering funds, while the service case manager could focus on advocacy.

Another advantage to this model is that targeted case management may be used to fund a broad population. The population served under the Home- and Community-based Waiver, in contrast, is generally restricted to persons at risk of institutional care.

The introduction of the private sector into the system could have several benefits. For one, it would increase competition and consumer choice, which could result in higher quality, less expensive case management services. Further, letting the private sector compete could result in reduced caseloads and the use of a greater variety of innovative approaches. This is important, given that client needs are diverse and no one model for case management appears to be successful.

A further advantage to the split-functions model is that it is likely to meet with federal approval. The Health Care Financing Administration has indicated a willingness to work with Minnesota to develop this model. This approach also would not involve the research and demonstration time likely to be required of Models III and IV.

A disadvantage of splitting administrative and nonadministrative roles is that it fragments the case management system, whereas a goal of most case management

systems is to simplify. Advocates in North Dakota have opposed the splitting of case management functions in that state on the grounds that it contributes to fragmentation, the very problem case management was established to address.

This model does not address potential federal concerns related to user fees and possible duplication of efforts between case managers and Qualified Mental Retardation Professionals. In the latter case, California's experience suggests that targeted case management probably cannot be used to fund case management services being conducted by Qualified Mental Retardation Professionals in intermediate care facilities for the mentally retarded.

Another disadvantage to the split-functions approach is that creating a role for the private sector could mean losing some public control over service delivery. This is important for a service that is costly and serves a vulnerable population. With more providers, and with both public and private providers, control may be more difficult.

Another problem with this model is that it does not control the cost of case management services. With an additional funding source available, counties would be able to comply more fully with Rule 185. This could greatly increase costs without a proportional increase in the quality of services.

More importantly, this model does not include any measures to control the costs of developmental disability services. It does not set a limit on costs or set priorities among clients in need of services, nor does it limit the state to being the direct service provider of last resort.

## **Conclusion**

Significant advantages to this model include an increase in federal funding for case management, resulting in savings to the counties, a reduction in conflicts of interest and greater client choice.

The model also appears to fit within current funding streams and policies, although there would be issues to resolve with federal officials.

Most importantly, however, this model contains no mechanisms to control costs of either case management or overall system services.

# **MODEL III: Consolidated fund case mix**

## **Introduction**

This model uses a consolidated fund case-mix strategy for allocating resources. It envisions a more flexible approach to county case management.

## **Rationale**

This model developed from discussions about what an ideal case management system would look like. Such a system would be flexible and responsive to individual needs and would include a serious cost containment mechanism.

In this model, flexibility and responsiveness are enhanced by use of a sequenced approach, with the option of not proceeding through all stages, and by increased reliance on family members and other natural supports. Cost containment would be achieved through the use of a case-mix formula that allocates resources on the basis of individual needs and available public funds.

This model keeps case management within the counties. Although it does not use different providers for administrative and service functions associated with case management, it does separate these functions sequentially. Functions could be further separated by provider if a strict "free choice of vendor" approach becomes mandatory for federal approval of case management as a service when the Home- and Community-based Waiver is renewed.

## **Description**

This model for case management has three major components: gatekeeping (intake and needs assessment), planning/coordinating, and monitoring. Advocacy and cost containment functions are enhanced by the sequencing of activities.

The gatekeeping activities are the ones that must be performed by a public agency. These would be the administrative functions if "administration" and "service" need to be separated. These are seen as a two-stage process:

### **STAGE ONE: Short-form eligibility determination**

Purpose: To provide prompt, uncomplicated access to funds for individuals or families requiring minimal assistance (for example, respite care only).

Activities: Intake; general eligibility determination (for instance, Is the individual developmentally disabled?); information and referral if requested; authorization for allowable services under a prescribed dollar cap; periodic reauthorization.

Comments: Individuals and families requesting more comprehensive assistance could start the process at stage two.

## **STAGE TWO: Long-form eligibility determination**

Purpose: To determine an individual's needs and a corresponding level of public resources that can be used to meet those needs.

Activities: Full assessment to determine eligibility for services beyond the dollar cap at stage one; information and referral if requested; authorization for services.

Comments: This would require the development of a screening tool assessing functional ability, medical needs, family and social supports, at-risk factors and the individual's preferences and potential.

It would further require development of a case-mix rating system corresponding to the screening tool. The product of the assessment would be a case-mix rating and an authorization to spend up to a prescribed dollar amount for services. This approach is not intended to commit resources that are not available. State and county budgets for services to individuals with developmental disabilities would be a key component in setting the financial caps at the various case-mix levels.

Rather than starting from scratch, the screening tool and case-mix rating system could be created with reference to the waiver screening instrument and the intermediate care facility and day training and habilitation assessment scales and case-mix groups that are already in use or development. As in the Home- and Community-based Waiver, this would help maintain a link between institutional costs and allowable costs for community alternatives.

Case management services could potentially stop at this point. Parents *or* guardians could proceed on their own to arrange services within the prescribed cap (with modest documentation requirements for accountability). In instances where individuals or families want or need more assistance, they would proceed to stage three.

The remaining components of case management move out of the administrative and into the service areas.

## **STAGE THREE: Planning and coordination**

Purpose: To provide more intensive support services to those individuals and families needing or requesting them.

Activities: Development of an individualized service plan; advocacy within the financial constraints of the case-mix allocation; information and referral; case coordination.

Comments: There is an assumption that individuals without active family members or other natural supports would receive this service. However, levels of service would be flexible. For example, federal regulations require planning and

coordination by a Qualified Mental Retardation Professional for individuals in intermediate care facilities for the mentally retarded. This model would give counties discretion to reduce any duplication of effort between the case manager and the Qualified Mental Retardation Professional.

By sequencing and separating the gatekeeping and advocacy functions, role conflicts for case managers should be reduced. Working within a prescribed budget, they can be genuine advocates for their clients. Individual service plans would now identify needs and wants without committing counties to funding them.

#### **STAGE FOUR: Monitoring**

Purpose: To assess the adequacy and appropriateness of services.

Activities: Periodic communication and contact with clients and providers; comparing outcomes to goals; assessing changing needs.

Comments: Again, this is an activity that can be customized to meet individual needs. County monitoring could decrease if family members or friends are able to appropriately provide this service. County monitoring could increase in situations where providers are taking primary responsibility for planning and coordination (for example, in intermediate care facilities for the mentally retarded).

### **Advantages and disadvantages**

This model takes a serious approach to cost containment. It envisions a service system setting priorities and making choices within budgetary constraints set by policy makers.

It expands the paradigm shift from services driven by funding to services driven by individual needs. This is intended to facilitate the transition away from institutions and toward home- and community-based options.

This model empowers families and reduces mandatory dependency. It recognizes different levels of need for case management services and accommodates these differences.

It authorizes counties and case managers to use their professional judgment and common sense in providing services. It retains the system at the county level and thereby maintains local control and avoids further fragmentation. However, by separating administrative and service functions, case manager conflicts of interest are reduced and there is flexibility for contracting for activities if needed to secure federal funds or meet federal freedom-of-choice requirements.

Giving counties and parents more flexibility and discretion can also be seen as a disadvantage, depending on one's point of view. Reduced accountability to the state might increase risks to individual clients.

Other disadvantages of this model involve difficulties of implementation. Creation

of the screening and assessment tool and case-mix formulas with appropriate dollar caps would be time consuming and politically sensitive. This would require broad participation in planning and development. The challenge would be to create an approach that is fair and flexible enough to respond to changing needs, but that sets real limits on public expenditures.

A particular difficulty in creating a case-mix formula for this population is the lack of consensus on which types of clients need the most services. Arguments can be made in favor of the highest functioning clients (because of their potential for community integration and increased self-sufficiency), the most medically needy clients or those with the most challenging behavioral issues.

Feasibility of implementation is also an issue with respect to federal funding and related requirements. The transition from funding streams driving services to a consolidated fund approach would require federal approval on a demonstration project basis.

## **Conclusion**

Conceptually, this model is extremely attractive in its ability to meet most of the evaluative criteria described in Part 1. For example, it tailors services to individual needs, includes cost containment mechanisms, supports the transition away from institutional care and reduces conflicts of interest.

However, refinement and implementation would present a challenge for Human Services' leadership. If a political constituency for this model can be developed, Human Services should begin discussions with federal Medicaid authorities regarding the federal barriers to implementation.

# MODEL IV: Managed care

## Introduction

In this model, case management and related services are provided by managed care organizations. In this context, a managed care organization for persons with developmental disabilities is defined as an organization that provides basic case management services such as assessment, planning and coordination, provides a full range of other services as needed (directly or through subcontracts), and assumes the full financial risk of the benefit package provision. Managed care organizations for persons with developmental disabilities would receive a fixed prepaid amount for each enrollee to provide the enrollee with the services she or he needs.

Unlike managed care organizations now in place for other populations (for example, health maintenance organizations), these managed care organizations would not be providers of medical services, but of a range of residential and habilitative services.

## Rationale

This model allows the state to plan and control the overall cost of developmental disability services by setting capitated payment rates. The managed care organizations have incentives to control costs within their plan because they receive the same prepaid amount per enrollee regardless of the actual costs of services. An emphasis on cost control can result in the greater use of home- and community-based services, and can promote careful case planning and follow-up.

This model also allows for maximum flexibility in meeting diverse client needs. Within the cost of the capitated payments, organizations can design service packages to meet individual needs and preferences.

This model is based on a proposal by InterStudy, a health care research organization, in which the role of HMOs and other managed care organizations is expanded to allow these organizations to provide a full range of acute and long-term care services to Medicare beneficiaries (InterStudy, 1989).

## Description

Managed care organizations would provide the following case management functions:

intake	coordination of services
needs assessment	internal monitoring
individualized planning	

In addition, the managed care organizations would provide all related developmental disability services, either directly or through subcontracts.

The managed care organizations would be required to offer clients a range of

services that is not based on a medical model, and to document the appropriateness of care packages.

The county's role in this model would be at least threefold:

1. gatekeeping (establishing and monitoring reimbursement formulas and procedures, and monitoring overall costs);
2. contracting with providers; and
3. monitoring providers to ensure that care is appropriate and that client complaints are resolved.

## **Advantages and disadvantages**

One advantage to a managed care approach is that it is designed to control costs. Managed care organizations "do well when the average actual cost of care is below the capitated amount they receive. This is powerful incentive to provide cost-effective care" (InterStudy, 1989).

Capitated payments and an emphasis on cost control can also allow the state to transfer the risk of the cost of care to the private sector, and to plan, control and document expected cost increases. By promoting the use of the private sector, this model is consistent with using the state as a provider of last resort.

An emphasis on cost effectiveness can have significant benefits to the client as well as to the system as a whole. In their attempts to contain costs, managed care organizations for persons with developmental disabilities will have incentives to provide less expensive home- and community-based alternatives to institutional care, to prevent crises, and to effectively manage transitions from one setting to another.

Another advantage to this model is that the managed care organizations are given capitated payments based on the needs of their enrollees, and have discretion in service planning and delivery. This allows the organizations to design and implement an individualized service package based on client needs, rather than pursuing those specific options for which funding is available (for example, intermediate care facilities).

Further, by providing both case management and associated services to clients, the managed care organization would be a relatively simple system for clients to understand and access. The organization staff would also be in a position to know about client needs, develop specific services to meet those needs, and provide and monitor the services the client is receiving. This would allow for relatively easy coordination of services and assessment of the client's overall care package.

A major concern with this model is that the focus on cost containment will distract providers from delivering care that best meets client needs. While in some cases cost containment would lead to ensuring appropriate care (for example, by preventing crises), in other cases advantages to the client may simply increase costs for the managed care organization.



Another concern is that the managed care organization may have incentive to refer clients only to those services it provides directly. This could limit the choices available to consumers, reduce the use of generic services, and result in less integration for clients.

Without an effective capitation formula or other controls, this model could result in an unfair system where persons with the greatest needs are least likely to receive care. Prepaid reimbursement systems typically pay the managed care organization an amount per enrollee based on the average cost of care, adjusted for certain factors such as client age and health status. Managed care organizations have incentives to enroll clients who are likely to cost less than average (favorable selection), and avoid enrolling clients whose cost of care will be above average (adverse selection).

A related concern is that the development of managed care organizations for persons with developmental disabilities may result in regionally based, rather than locally based, systems. Depending on the sophistication of the reimbursement formula, managed care organizations may have to serve a relatively large population that includes a mix of high-cost and low-cost enrollees in order to be financially viable. This may result in regional managed care organizations.

Finally, the establishment of managed care organizations for persons with developmental disabilities does not fit into current developmental disability services funding streams. This type of system would require discussions between federal and state authorities to examine the feasibility of establishing this model as a demonstration project or through a waiver (or waivers). The Health Care Financing Administration indicates that research and demonstration waivers are difficult to obtain and that the funding of long-term care for persons with developmental disabilities is not a current funding priority.

## **Conclusion**

A system based on managed care organizations for persons with developmental disabilities has the significant advantage of allowing the state to better plan for and control the cost of developmental disability services. Managed care organizations also have the flexibility to provide individualized service packages based on needs rather than on funding source. However, a managed care system has built-in incentives to not provide those services that may be beneficial to the client but will not reduce costs. If a managed care system is developed for persons with developmental disabilities, it must include close monitoring by the public sector to ensure that client needs are being appropriately met.

An appeals process and satisfactory system for measuring the quality as well as the cost of services would have to be developed if this model is to be successfully implemented. Outcome-based criteria that include measures of the client's quality of life, functional abilities, integration with society at large, and ability to live independently should be incorporated into the monitoring process.

Because this model holds both risk and promise, it may be best implemented as a demonstration project. Obtaining Health Care Financing Administration approval for a demonstration project at this time may be difficult.

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## **CONCLUSIONS AND RECOMMENDATIONS**

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# CONCLUSIONS

Minnesota's case management system can improve the quality of life for persons with developmental disabilities by providing an individualized, holistic approach to client services and by assisting in the transition from institutional to community alternatives.

Despite its intentions and accomplishments, Minnesota's case management system for individuals with developmental disabilities is failing in some fundamental respects:

- The human needs of individual clients are getting lost in a paper shuffle of burdensome administrative procedures.
- A lack of consensus about the purpose and definition of case management results in role confusion and inconsistent case management policy.
- The case management process fails to systematically set priorities or manage scarce resources in the public interest.
- Hostile relationships among the state, counties and service providers have been exacerbated.

There are no obvious or easy solutions. It will not be sufficient to reduce caseloads, improve training or seek new funding sources for case management. Minnesota's case management system has more fundamental problems. More fundamental changes are needed:

- **A new emphasis on cost containment:** The 1986 statement of need and reasonableness for Rule 185 acknowledged the role case management should play in cost containment. Annual public expenditures for services to individuals with developmental disabilities in Minnesota increased approximately 43 percent from Fiscal Year 1986 through Fiscal Year 1990, rising from more than \$408 million to more than \$583 million. Costs of case management services increased by 123 percent over the same period.

While many factors account for this growth, it is clear that the case management system must be modified to become a vehicle for containing costs within the service system. When case management is viewed only as a service to clients, the state misses a critical opportunity for managing costs.

- **A new emphasis on innovation and experimentation:** Because there is no obvious single solution to the problems of case management, Minnesota should launch a period of pilot tests and experiments designed to test various models and strategies. Pilot tests should assess new methods for funding services, controlling costs, reducing case manager conflicts of interest, improving access to noninstitutional alternatives and measuring quality.
- **A new strategy for quality and compliance:** The current system relies on the heavy regulation of process to promote the delivery of case management services.

Counties are unable or unwilling to comply with the regulations, and the quality of services varies widely among counties. The heavy emphasis on process often detracts from, rather than enhances, a case manager's ability to do a good job.

Considerable support exists among stakeholders for the concept of outcome-based measures of quality. The concept holds promise because there is more consensus on desired outcomes (for example, increased client independence) than on case management processes and methods.

- **A new state/county relationship:** Ultimately, the quality of case management depends on motivated, caring individuals at the local level who understand their role and strive to balance client and system needs. The state's attempt to heavily regulate this subjective, client-specific activity is unrealistic. Individual case managers in 87 separate counties cannot be directed from St. Paul. Attempts to do so stifle professional employees and interfere with local priority setting.

Since counties deliver and pay for much of the cost of case management services, counties must be active partners in redesigning the system. For the short term, counties should be given the latitude to develop innovative approaches on a pilot basis.

Common sense and flexibility need to be rediscovered. Case managers must be allowed to operate with a reasonable level of authority and autonomy in environments of trust, participation and creative problem solving.

The state role should shift from heavy regulation to technical assistance and intervention if significant problems occur.

- **A new service model:** The recommendations that follow describe various approaches to the fundamental changes needed. They are applicable to a short-term period of experimentation as well as to a longer-term redesign of Minnesota's case management system.

# RECOMMENDATIONS

1. Minnesota policy should ensure that case management will be used to serve two functions: meeting the needs of individual clients and controlling costs and utilization of services.
2. Case management alternatives were described in Part 4. Related recommendations follow:

**Who should receive case management?** Minnesota should not restrict eligibility for services but should adopt a more flexible approach that acknowledges differing levels of need and the role that parents, family members and other natural supports can play in planning, coordinating and monitoring services.

**Who should provide case management services?** Adding new providers and the resultant administrative systems would further complicate case management. Generally, counties should continue to provide or contract for case management services. This should not, however, exclude locally designed experiments with alternative service providers.

**Who should fund case management?** Minnesota should continue to fund case management through Medicaid administrative funds, the Home- and Community-based Waiver and Community Social Services funds, while working to resolve other problems identified in this report.

Efforts to solve case management problems with new money alone should be resisted. Targeted case management dollars are an attractive new funding source that would shift some of the Fiscal burden for case management from the counties to state and federal revenues. However, this source would require the development of user fees and would not be available to individuals in intermediate care facilities for the mentally retarded. Also, costs for case management could be expected to go up even more dramatically. (Historically, the services that expand in Minnesota are those paid for by Medical Assistance.)

Targeted case management dollars should be pursued only as part of a broader strategy in which case management becomes a vehicle for systemwide cost containment, or as a pilot including cost-effectiveness measures in a strictly limited geographic area.

If targeted case management is not developed, weaknesses of current funding sources should be addressed. This would involve improving the system for documenting reimbursable administrative costs and resolving problems that threaten case management as a service upon renewal of the Home- and Community-based Waiver. (The latter could require use of providers other than the counties.)

**To what degree should case management be regulated?** The state's efforts to force accountability through strict regulation have not been successful. Within the constraints of federal mandates, the case

management process should be streamlined and simplified. The goal should be to provide counties and case managers with reasonable levels of discretion and freedom to act. Although design and implementation would be difficult, there is considerable support for the concept of outcome-based accountability measures. This approach should receive special attention through the period of pilot tests and experimentation.

**3.** Case management models were described in Part 5. Related recommendations follow:

**Model I - Rule 185 streamlined:** Simplification and streamlining of Rule 185 are essential regardless of any additional actions taken. This should be done in collaboration with the counties and with input from interested parties. However, streamlining alone does not resolve several critical problems.

**Model II - Split functions:** This model could assist the state in obtaining more federal money for case management. As noted above, however, relying on targeted case management as a new funding source runs the risk of increasing costs for case management without controlling overall system costs. Model II should be pursued only after effective cost containment mechanisms have been incorporated into the case management process.

**Model III - Consolidated fund case mix:** This model attempts to address many of the significant problems with Minnesota's overall system and uses case management as a tool for both individual advocacy and cost containment. Conceptually, it is the most attractive of the four models. However, it would be difficult to implement. The leadership challenge for the state is to interest the federal government in experimenting with a new resource allocation model. If successful, the state should involve counties, advocates and other interested parties in the refinement and development of appropriate demonstration waivers.

**Model IV - Managed care:** This model holds promise for effective cost containment but runs the risk of not adequately protecting the interests of vulnerable clients. If federal funding stream problems can be resolved, it is recommended for further development on a pilot basis, but only with strong external monitoring of services and providers.

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