

HCBS Partners Panel Meeting Notes

Hi-Way Federal Credit Union

February 15, 2019

Welcome, Introductions

Aron Buchanan, Aging and Adult Services

Reform 2020

Jan Kooistra, *Federal Relations, Health Care Administration*

Cara Benson, *Disability Services Division*

Rachel Shands, *Aging and Adult Services*

Presentation on DHS' Reform 2020 waiver (See handouts)

Q: Did the evaluation give any reasons for the relatively low use of CDCS?

A: The evaluation did not study this particular question. That said, because CDCS budgets are lower than traditional services budgets, this may be a barrier for some individuals to choose CDCS.

Q: Did you give us a timeline for the transition to CFSS?

A: The transition to CFSS is scheduled for mid-2020.

Q: How does Minnesota's use of CDCS compare with other states?

A: Although the number of people who self-direct is counted by state nationally, it is difficult to compare CDCS in Minnesota with consumer directed options in other states because every state sets up their programs and services differently.

Q: How does Minnesota's use of CDCS compare with other states?

A: It is difficult to compare CDCS in Minnesota with consumer directed options in other states because every state sets up their programs and services differently, and each state defines self-direction differently. We work with a national group that has a count of self-directed services by state and, in general, self-direction has increased over the last several years.

CM Redesign

Jennifer Blanchard, *Director, Community and Care Integration Reform, Health Care Administration*

Lisa Cariveau, *Case Management Redesign Lead, Health Care Administration*

Presentation on DHS' Case Management Redesign initiative (See handouts)

Comment: ARRM and our members appreciate the work you're doing on this. We will be providing weekly feedback on this topic while DHS is seeking it.

Q: Will this apply to case management services that are not federally funded?

A: The scope of this project is Medical Assistance (MA) funded case management. That said, the department is also taking into consideration all of the case management services that lead agencies and mental health authorities are required to provide.

Q: Can you speak to the design team's discussion relating to choice of case manager and case management provider agency?

A: The 2012/13 legislative requirement was to increase opportunities for choice. The initial design team discussed what this really means and had quite a lot of discussion around a person's choice to choose their case manager within an agency. The team also explored agency choice, and concluded this is bigger than case management and gets into overall governance structure. Because this is a broader issue, not as much focus was given to the topic of agency choice.

As a part of this work, mental health authority governance is not being modified. Also, Reform 2020 and Waiver Reimagine are other reform initiatives that we're thinking of how case management fits within.

Also, when looking at statute and rule about what's included in case management, there's often an intersection of both administrative and service activities. We are trying to clarify the service of case management, separate from administrative and gate-keeping activities that determine eligibility and are involved with resource management activities.

Q: In light of the workforce shortage challenge we're facing over the next ten to fifteen years, have you asked or surveyed case managers what they think is effective or not effective about their work in order to gain insight about providing quality case management?

A: Workforce came up a lot during conversations, in particular during discussion around competencies and qualifications. What we've heard from case managers is that they enjoy when they are able to work directly with individuals and their families. Challenges that came up included things like the lack of service availability to which to connect people. The reality of high turnover has also come up as a theme.

Case managers and people receiving case management commented on similar themes relating to what they feel are challenges as well as what's working well (e.g., not having enough time or resources).

Also, some of the earlier case management studies discussed ways to target activities (e.g., different levels and expectations of case management at different times in a person's life, depending on the person's needs).

Comment: I agree there's a tension between the administrative gatekeeping and the service function of helping people access the services and supports they need. That said, when I look through the goals of this project it looks a lot like a support planner with a little addition of ongoing monitoring. So, I think if we moved in the direction of separating these functions from the gatekeeping function, it would bring more satisfaction to case managers who could choose the role they feel would be a best fit for them, versus having to fulfill two or three roles at once. This would also help to decrease role confusion.

Q: Is one of the purposes of the design team to define the qualifications and experiences necessary and are you contemplating broadening that?

A: The design team primarily discussed and focused on competencies rather than qualifications. You'll see in the document a list of competencies, which is important to keep in mind as we think about developing core training for all case managers. Next steps include looking at qualifications and what's needed in statute to support this.

Conversations also occurred around specialized types of case managers (e.g., case managers to help with a very specific question or task, versus service coordination, versus a case manager that might be able to help with

paperwork). This relates to the competencies discussion, as the different case managers can have specialized competencies which creates greater opportunity.

Comment: I appreciate this response, and I think these are important points that should be incorporated into your PPT.

Q: The term case management has some historical limitations. Has the Department considered changing the term that's used to support planner, service coordinator or some other term that emphasizes what's being done that separate from the gatekeeping role?

A: This topic has certainly been discussed, making note that managing cases is not the most person-centered way to look at things. At the same time, because case management is the term that's used and defined in federal law, the requirements around that has been the focus of the project. Also, it's important to have a common and consistent understanding of what the term means, which has been the focus of our conversations, versus the term itself.

Stakeholder Meeting for Seniors and People with Disabilities in Managed Care

Michelle Lichtig, *Special Needs Purchasing Policy Coordinator, Special Needs Purchasing*

Gretchen Ulbee, *Manager, Special Needs Purchasing*

Presentation on DHS' stakeholder meeting for seniors and people with disabilities in managed care (See handouts)

Q: Can you repeat when the meeting is?

A: It's March 11th at 1 p.m. at DHS Anderson Building, room 2370.

HCBS Access Project

Mary Olsen-Baker, *Aging and Adult Services Division*

Sara Galantowicz, *Project Director, Abt Associates*

Presentation on DHS' HCBS Access project (See handouts)

Note, the information in the detailed PowerPoint contains preliminary data, so the PPT is not posted to the HCBS Partners Panel web page. If you would like to receive a copy of the PPT, or provide further feedback on the presentation (e.g., if the measures makes sense, how they might be used, the usefulness of the filter), contact Mary Olsen Baker at mary.olsen.baker@state.mn.us or Julie Angert at Julie.angert@state.mn.us.

Q: Can you clarify where you're getting the PCA data (i.e., is the PCA data about individual enrolled providers, vs. PCA agencies)? Also, do the home health numbers represent agencies?

A: We're counting the providers which are getting reimbursed for the service. PCA is unique in that it's a combination of provider agencies and individual providers.

Comment: This doesn't address that you can have relatively stable number of agencies over time, but agencies limit the number of individuals they serve on the waiver. For example, I'm aware of several agencies that reserve services to those on the waiver who had previously been long-term, privately paid clients.

Response: This is a good point and is addressed in measure number three which looks at the level of service providers deliver. It's important to remember that just because you have providers doesn't mean there's not a provider capacity issue.

The other point is that although there are several services displayed for this measure, the real power of the measure is tracking the trend of any one of the individual service types over time.

Q: Can you clarify who the people are that are included on the slide relating to the number of providers per 1000 people with disabilities and on public insurance? Does this include older adults?

A: This comes from the American Community Survey (ACS) data and includes people of all ages.

Q: How does this definition align with how we identify these populations in our programs (i.e., how closely those two numbers trend)?

A: We refer to this data as a proxy because while there will be some degree of alignment between the dimensions of disability, there probably won't be a one to one match. The definition of disability from the ACS is probably broader than the threshold that might be necessary to qualify for Minnesota programs.

DHS is aware of the concerns of how ACS is based on census data and that the disability community disagrees with how the census identifies people with disabilities (e.g., they don't identify kids well). Regardless, the data does provide a proxy and the power of the measure is what it will show over time.

These are measure concepts and a place to start. We can evaluate how relevant and useful these measures are over time as we use them.

Comment: I think it would be useful to know the comparison numbers. To make sense of the data, it would be helpful understand those differences.

Response: I'd like to add, we should try to use the term 'potential' users when we are thinking about the individuals with disabilities on public insurance because when you're thinking about whether or not your supply is adequate, there's an element of asking if it's adequate for the people already on the program and/or adequate for the people who could be on the program? Both are important access issues.

Q: Will we get the slides for this after the meeting?

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Comment: The measure relating to the capacity of providers over time may reflect funding or policy changes over time.

Q: Is it possible to show the combined data of fee-for-service and managed care, or even the totals, to get a better sense of the number of providers?

A: We chose to provide percentages versus numbers, but yes, we could also include the numbers.

Q: Were you able to determine if providers were enrolled in both fee-for-service and managed care categories?

A: We did not look at the provider enrollment status, but I'll take another look at this to see if providers submitted both types of claims and how that might impact the measure.

Q: Will this be reported out by the state designated regions?

A: We look at three different ways to define geography for filters: one is by county, one is economic development region, and the last one is the Rural Urban Commuting Area (RUCA,) which divides the state up by urban, rural, and a couple other gradations between urban and rural).

Q: When we get to interact with this, will we be able to overlay client information with provider information so that we can compare the trends?

A: We're starting to discuss with the state the business requirements for this dashboard, and it sounds like it can be put on the list as something to discuss.

Q: Have you looked at the difference between traditional PCA versus PCA choice?

A: Although MMIS doesn't distinguish between the two services with the billing code, this does bring up the earlier point that we should be able to use a combination of different data to see and understand how utilization is different under PCA choice versus traditional PCA. This could be something we can look at developing in the future.

Comment: I bring up this issue because it brings up two different access questions. The first is for the person accessing PCA Choice where the person knows someone that can provide the service. Whereas with traditional PCA, the person does not have this resource. So this is a different question or point of analysis relating to access. Because we want to move towards a system that is more self-directed, it is important to be able to tease out this difference.

Q: Is it possible to include people who are admitted into Anoka Metro Regional Treatment Center (AMRTC) or forensics at St. Peter when they need HCBS? I ask because these are institutional settings.

A: Because these are not necessarily paid through Medicaid, there are other ways of getting that data. We are reporting how many people are being admitted to and discharged from these facilities in other projects.

Q: Is the denominator the entire MA population or the cohort of race?

A: We took the entire MA population and then stratified it by race to come up with a denominator. The numerator is the number of people within a racial category who also have a PCA claim in 2016.

Q: Is there a way to break out this by age as well as sex (male and female)?

A: This gets into the earlier dashboard discussion and interest in double stratification, which can be explored in the future. One thing we need to keep in mind when stratifying by more than one factor is how small the population might get.

Comment: You may want to review the terms you're using for what is most acceptable (e.g., Hispanic is not a race, rather Hispanic is an ethnic group which may include various races).

Response: We capture ethnicity as either Hispanic or non-Hispanic which is captured in MMIS in addition to the race categories on the slide. We'll verify how we categorize a person when they identify as Hispanic in relation to race, as I don't believe they're mutually exclusive. We will also change the title to incorporate both race 'and' ethnicity.

Q: Why were the substance abuse and psychiatric issues eliminated?

A: In one of the future refinements, we may want to consider incorporating this in the current measure by having a separate category rather than calling it unclassified if you're interested in looking at emergency department (ED) visits for people with these diagnosis.

Q: Do we see other states using the potentially avoidable ED visit use as a measure of home and community-based services (HCBS) access?

A: There was work done years ago sponsored by the federal government looking at ED visits and potential hospitalizations among HCBS users. There is robust literature that looks at possible prevention of initial hospitalizations and readmissions among HCBS users.

Q: Did you say that the data is based on primary diagnosis, and that it doesn't get at dually diagnosed individuals?

A: To be flagged as having a mental health diagnosis for this measure, we look at all of the claims submitted for an individual, and if at least one inpatient claim or two outpatient claims includes a mental health diagnosis as the 'primary' diagnosis, then the person is included.

Q: This seems like a measure that is difficult to have a high degree of confidence in the usefulness of the measure. It doesn't look like it includes people who might have private insurance and are HCBS users but are using their private insurance to access mental health services.

A: There are certain populations of individuals where they are more likely to have private insurance in addition to MA, and we are able to get the data on this to get a better understanding of the issue.

Q: Can we see a distinction of different service types and the gap between planned versus utilized services?

A: Yes, we can look at these measures using different services. This is one of the conversations we're having with DHS as we develop the dashboard—identifying which are the most important services to analyze.

Q: Will you also be able analyze this by waiver?

A: Yes, this is currently one of the filters.

Comment: I imagine this information would help to maximize the budgets for each of the services?

Response: Once you're on a waiver, you can choose to use services in a variety of different ways (e.g., if a person has success using PCA, they could certainly decide to use Extended PCA. Conversely, they could choose a different service to meet their needs). So, there's a lot of flexibility that people have in setting up the right combination of services to meet their individualized needs.

Q: When will the dashboard be available?

A: The dashboard is supposed to be ready by June 30, 2020.

[Closing](#)

Aron Buchanan, Aging and Adult Services