Reform 2020: Pathways to Independence

Section 1115 Waiver No. 11-W-00286/5

Demonstration Year VI
January 1, 2019 through March 31, 2019
Quarterly Report

Submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services

Submitted by:

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1. Introduction

On October 18, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Minnesota's section 1115 demonstration project, entitled Reform 2020. The five year demonstration provides federal waiver authority to implement key components of Minnesota's broader reform initiatives to promote independence, increase community integration and reduce reliance on institutional care for Minnesota's older adults and people with disabilities. Federal waiver authority for the five-year demonstration was scheduled to expire on June 30, 2018. On July 19, 2017 the state submitted a request to renew the Reform 2020 waiver through June 30, 2021. The Reform 2020 waiver is currently operating under a temporary extension through April 30, 2019. The current STCs and expenditure authorities continue to apply during this temporary extension.

1.1 Alternative Care Program

The Alterative Care program provides a home and community services benefit to people age 65 and older who need nursing facility level of care and have income or assets above the Medical Assistance (MA) standards. The Alternative Care program was established as an alternative to provide community services to seniors with modest income and assets who are not yet eligible for MA. This allows people to get the care they need without moving to a nursing home. The Reform 2020 demonstration waiver provides federal matching funds for the Alternative Care program.

1.2 Community First Services and Supports (CFSS)

Minnesota is redesigning its state plan personal care assistance services to expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after the Community First Choice Option. It will reduce pressure on the system as people use the flexibility within CFSS instead of accessing the expanded service menu of one of the state's five HCBS waivers to meet gaps in their needs.

The new CFSS service, with its focus on consumer direction, is designed to comply with the regulations regarding section 1915(k) of the Social Security Act. Minnesota is currently seeking federal approval of the 1915(i) and 1915(k) state plan amendments required to implement this PCA reform initiative. To avoid a reduction in services for people currently using PCA services, CFSS will be available both to people who meet an institutional level of care [via 1915(k)] and people who do not [via 1915(i)]. These two components of CFSS are designed to work together seamlessly to provide appropriate services to people who have a functional need. Services authorized under 1915(i) will be identical to those authorized under 1915(k). The enhanced FMAP rate will apply to the 1915(k) services and the regular FMAP rate will apply to the 1915(i) services. Appropriateness of CFSS services will be based on the CFSS functional eligibility criteria.

Federal authority under the Reform 2020 section 1115 demonstration waiver allows Minnesota to extend the CFSS benefit to people who would not be eligible to receive such services under the state plan. Under the Reform 2020 demonstration waiver, a 1915(i)-like benefit will be available for people with incomes above 150% of the federal poverty level (FPG) who do not meet an institutional level of care and who receive the reformed PCA benefit (CFSS). The regular FMAP rate will apply to these services. A 1915(k)-like benefit will be available for people who meet an institutional level of care, receive the reformed PCA benefit (CFSS), are not receiving HCBS waiver services and are financially eligible if using financial eligibility rules for HCBS waivers. The regular FMAP rate will apply to these services. CFSS will be implemented for all populations once Minnesota's 1915(i) and 1915(k) state plan amendments are approved by CMS. Reporting on the 1915(i)-like and 1915(k)-like component of the Reform 2020 demonstration will begin once approval of the state plan amendments has been secured and implementation has begun.

On March 12, 2018 DHS informed CMS of the state's intent to withdraw the authorities in the Reform 2020 waiver related to CFSS. The state intends to retain all other federal waiver and expenditure authorities approved under the Reform 2020 waiver special terms and conditions for the Alternative Care program and coverage of children under 21 with activities of daily living needs described in Section 1.3 and 7.1 of this report.

1.3 Children under 21 with Activities of Daily Living (ADL) Needs

The Reform 2020 waiver provides federal expenditure authority for children under age 21 who are eligible under the state plan and who meet the March 23, 2010 institutional level of care criteria, but do not meet the institutional level of care criteria established in state law effective January 1, 2015, and would therefore lose Medicaid eligibility or home and community based services eligibility. Please refer to Section 7.1 of this report for more detail.

1.4 Goals of Demonstration

The Reform 2020 waiver provides federal support for the state's Alternative Care program. The Alternative Care program is designed to assist the state in its goals to:

- Increase and support independence and recovery;
- Increase community integration; and
- Reduce reliance on institutional care.

2. Enrollment Information

Demonstration Populations (as Hard coded in the CMS 64)	Enrollees at close of quarter (March 31, 2019)	Current Enrollees (as of data pull on April 5, 2019)	Disenrolled in Current Quarter (January 1, 2019 to March 31, 2019)
Population 1: Alternative Care	2,594	2,577	12
Population 2: 1915(i)-like			
Population 3: 1915(k)-like			
Population 4: ADL Children			

Population 4: ADL Children During the period of January 1, 2019 through March 31, 2019, there were 2 children identified as meeting the criteria outlined in the Special Terms and Conditions paragraph 18 for the ADL Children eligibility group. All services received by these children were provided on a fee-for-services basis. Service expenditures for these children are reported each quarter on a separate Form CMS-64.9 Waiver.

3. Alternative Care Program Wait List Reporting

There is no waiting list maintained for the Alternative Care program and there are no plans to implement such a list.

4. Outreach and Innovative Activities

4.1 Minnesota Department of Human Services Public Web Site

Information on the Alternative Care program is available to the public on the Department of Human Services (DHS) website. The Alternative Care web page provides descriptive information about program eligibility, covered services, and the program application process. The web page also refers users to the Senior LinkAge Line® (described in the following section) where they can speak to a human services professional about the Alternative Care program and other programs and services for seniors.

4.2 Senior Linkage Line®

The Senior Linkage Line® is a free telephone information service available to assist older adults and their families find community services. With a single call, people can find particular services near them or get help evaluating their situation to determine what kind of service might be helpful. Information and Assistance Specialists direct callers to the organizations in their area that provide the services in which they are interested. Specialists can conduct three-way calls and offer follow-up as needed. Specialists are trained health and human service professionals. They offer objective, neutral information about senior service and housing options.

4.3 Statewide Training

DHS staff provides on-going consultation and training on Alternative Care program policy to all lead agencies. For the Alternative Care program, the lead agency can be a county social service department, local public health agency or a Tribal entity. Training sessions on the Alternative Care program are offered twice a year via statewide video conferencing. These training sessions cover the policies and procedures for the Alternative Care program. The training targets staff with up to 12 months of program experience. Staff with more experience is encouraged to attend if they have not previously attended or need a refresher in the program basics. The learning objectives for the training include understanding the Alternative Care program eligibility

requirements and service definitions, and case manager roles and responsibilities in administering the Alternative Care program.

DHS also publishes and maintains provider and MMIS manuals and provides technical assistance through a variety of means including written resource material, electronic and call-in help centers and weekly training opportunities via statewide video conferencing on topics related to aging. Ongoing training related to MMIS tools and processes, long term care consultation and level of care determinations, case management, vulnerable adult and maltreatment reporting and prevention is also provided. DHS staff regularly attends regional meetings convened by lead agencies.

5. Updates on Post-Award Public Forums

In accordance with paragraph 32 of the Reform 2020 special terms and conditions, DHS held a public forum on February 15, 2019 to provide the public with an opportunity to comment on the progress of the Reform 2020 demonstration. An overview of the February 15, 2019 public forum is provided at Attachment A. DHS plans to hold the next public forum in January 2020.

6. Operational Developments and Issues

6.1 1915(i) and 1915(k) State Plan Amendments

Two types of federal authorities are necessary for the state to implement CFSS – both state plan and waiver authorities. Implementation of the 1915(i)-like and 1915(k)-like components of the Reform 2020 waiver is contingent upon approval of the corresponding 1915(i) and 1915(k) state plan amendments. Due to systems modernization efforts, projected implementation of the CFSS benefit has been delayed. On February 5, 2018 DHS withdrew the 1915(i) and 1915(k) state plan amendments related to Community First Services and Supports.

6.2 CFSS 1915(b)(4) Waiver

On June 20, 2014, DHS submitted a 1915(b)(4) selective contracting waiver request to limit the number of financial management services contractors and consultation service providers.

Under CFSS, people may directly employ and pay qualified support workers and/or purchase goods or environmental modifications that relate to an assessed need identified in their service delivery plan. Spending must be limited to the authorized amount. A financial management services contractor (FMS) will be the employer-agent assisting participant-employers to comply with state and federal employment laws and requirements and for billing and making payments on behalf of participant-employers. In addition, participants will utilize a consultation services provider to learn about CFSS, select a service delivery model, and develop a person-centered service delivery plan and budget and to obtain information and support about employing, training, supervising and dismissing support workers.

On March 12, 2018 DHS informed CMS of the state's intent to withdraw the CFSS Consultation and Financial Management Services 1915(b)(4) waiver request.

6.3 Alternative Care Program Operational Protocol

The operational protocol was updated to incorporate changes made to the program after the State's 2017 legislative session and submitted on July 19, 2017 as Attachment A of the state's request to renew the Reform 2020 waiver. Amendments to the EW waiver effective July 1, 2018 resulted in additional changes to the operational protocol which were submitted in August 2018.

7. Policy Developments and Issues

7.1 Delay in Changes to the NF LOC Standard and Children with ADL Needs

In 2009, the Minnesota Legislature passed legislation that changes the nursing facility level of care criteria for public payment of long-term care services. These revised criteria were implemented on January 1, 2015. The change affects people who would receive publicly-funded nursing facility services or publicly-funded long-term care services in the community through programs such as Elderly Waiver (EW), Alternative Care (AC), and Community Alternatives for Disabled Individuals (CADI).

The Reform 2020 waiver provides federal expenditure authority for children under the age of 21 who are eligible under the state plan and who met the March 23, 2010 nursing facility level of care criteria, but who do not meet the revised nursing facility level of care criteria and would therefore lose Medicaid eligibility or home and community-based services eligibility. Quarterly reporting on the number of children meeting these criteria began January 1, 2015.

7.2 HCBS Settings Final Rule

The State has reviewed the final rule for the Medicaid home and community-based services settings, issued by CMS in January 2014. The final regulation addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services. In particular, the state has assessed requirements established in the rule for the qualities of settings that are eligible for Medicaid reimbursement for home and community-based services provided under sections 1915(c), 1915(i) and 1915(k) and the potential implications for Minnesota's personal care assistance services redesign initiative and the state's efforts to expand self-directed options under CFSS. On January 7, 2015 DHS submitted Minnesota's plan to transition to compliance with the CMS regulation governing home and community-based settings. The transition plan applies to all five of Minnesota's home and community-based waiver programs under authority of §1915(c) of the Social Security Act.

On June 2, 2017, the state received initial approval of systemic assessment and remediation strategies to be implemented under the Statewide Transition Plan. The final draft of the Statewide Transitional Plan was approved by CMS on February 12, 2019.

8. Financial and Budget Neutrality Development Issues

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10.

9. Member Month Reporting

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending March 31, 2019
Population 1: Alternative Care	2,650	2,629	2,644	7,923
Population 2: 1915(i)-like				
Population 3: 1915(k)-like				

10. Consumer Issues

10.1 Alternative Care Program Beneficiary Grievances and Appeals

A description of the State's grievance system and the dispute resolution process is outlined in the 1915(c) HCBS Waiver application and the 372 report for the Elderly Waiver. These processes apply to the Alternative Care Program. Grievances and appeals filed by Alternative Care program recipients are reviewed by DHS on a quarterly basis. Alternative Care program staff assist in resolving individual issues and identify significant trends or patterns in grievances and appeals filed. Following is a summary of Alternative Care program grievance and appeal activity during the period January 1, 2019 through March 31, 2019.

Alternative Care Program Beneficiary Grievance and Appeal Activity
January 1, 2019 through March 31, 2019

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	0	0	2

10.2 Alternative Care Program Adverse Incidents Consistent with 1915(c) EW Waiver Requirements

A detailed description of participant safeguards applicable to Alternative Care enrollees, including the infrastructure for vulnerable adult reporting, the management process for critical event or incident reporting, participant training and education, and methods for remediating

individual problems is outlined in the 1915(c) HCBS Waiver application and the 372 report for the Elderly Waiver.

Incidents of suspected abuse, neglect, or exploitation are reported to the common entry point (CEP) established by DHS. The CEP forwards all reports to the respective investigative agency. In addition, CEP staff also screen all reports for immediate risk and make all necessary referrals. Immediate referral is made by the CEP to county social services when there is an identified emergency safety need. Reports containing information regarding an alleged crime are forwarded immediately by the CEP to law enforcement. Reports of suspicious death are forwarded immediately to law enforcement, the medical examiner and the ombudsman for mental health and developmental disabilities.

For reports not containing an indication of immediate risk, the CEP notifies the lead agency responsible for investigation within two working days. The lead investigative agency provides information, upon request of the reporter, within five working days as to the disposition of the report. Each lead investigative agency evaluates reports based on prioritization guidelines. DHS has made use of a standardized tool required for county lead investigative agencies to promote safety through consistent, accurate and reliable report intake and assessment of safety needs.

Investigation guidelines for all lead investigative agencies are established in statute and include interviews with alleged victims and perpetrators, evaluation of the environment surrounding the allegation, access to and review of pertinent documentation and consultation with professionals.

Supported in part by funding under a CMS Systems Change Grant, DHS developed, implemented and manages a centralized reporting data collection system housed within the Social Services Information System (SSIS). This system stores adult maltreatment reports for the CEP. SSIS also supports county functions related to vulnerable adult report intake, investigation, adult protective services and maintenance of county investigative results. Once maltreatment investigations are completed the county investigative findings are documented within SSIS.

The SSIS system has the capacity to provide statewide maltreatment summary information, supplies comprehensive and timely maltreatment information to DHS, allows the department to review maltreatment incidents statewide and analyze by program participation, provider and agency responsible for follow-up. Data from SSIS is drawn on a quarterly and annual basis. This allows DHS to review data and analyze for patterns and trends including program specific patterns and trends that may be addressed through DHS and partners in maltreatment response and prevention, or policy. Maltreatment data gathered from SSIS is also used by DHS to evaluate quality in preventative and protective services provided to vulnerable adults, assess trends in maltreatment, target training issues and identify opportunities for program improvement.

Please refer to Attachment B for a report on allegations and investigation determinations of maltreatment where the county was the lead investigative agency and the alleged victim was receiving services under the Alternative Care program for the period January 1, 2019 to March 31, 2019.

The reporting of suspected maltreatment for all vulnerable adults in Minnesota recently changed from a county based reporting system to a centralized reporting system operated under DHS. The centralized reporting system includes more robust data for use in analysis for prevention and remediation. Modifications to the existing data warehouse are required to accommodate the increased data being reported. These modifications are underway and are expected to be completed soon. Reports which include allegations and investigation determinations of maltreatment where DHS or the Minnesota Department of Health was the lead investigative agency and where the alleged victim was receiving services under the Alternative Care program will be provided once this data becomes available.

11. Quality Assurance and Monitoring Activity

11.1 Alternative Care Program and HCBS Quality Strategy under the 1915(c) EW Waiver

As described in the 1915(c) EW waiver, the DHS Quality Essentials Team (QET) within the Continuing Care Administration will meet twice a year to review and analyze collected performance measure and remediation data. The QET is a team made up of program and policy staff from the Alternative Care and HCBS waiver programs. The QET is responsible for integrating performance measurement and remediation association with monitoring data and recommending system improvement strategies, when such strategies are indicated for a specific program, and when DHS can benefit from strategies that impact individuals served under the Alternative Care and HCBS programs.

Problems or concerns requiring intervention beyond existing remediation processes (i.e. system improvement) are directed to the Policy Review Team (working with QET) for more advanced analysis and improved policy and procedure development, testing, and implementation.
The QET has identified and implemented a quality monitoring and improvement process for determining the level of remediation and any systems improvements required as indicated by performance monitoring.

11.2 Update on Comprehensive Quality Strategy

Minnesota’s comprehensive quality strategy is an overarching, comprehensive and dynamic continuous strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota’s Medicaid program, Medical Assistance. A draft of the updated Comprehensive Quality Strategy was submitted to CMS on May 25, 2018 and posted to the DHS Quality Improvement web site for direct download.

12. Demonstration Evaluation

DHS has contracted with researchers at the University of Minnesota and Purdue University for development of an evaluation design and analysis plan that covers all elements outlined in paragraph 60 of the Reform 2020 waiver special terms and conditions. A draft evaluation design was submitted to CMS on February 14, 2014. In response to CMS feedback, DHS modified the draft evaluation design so that it aligns with the desired format for section 1115 demonstrations. A revised evaluation design was submitted on December 9, 2014. On April 6, 2015 CMS provided additional feedback and requested an updated evaluation. DHS has revised the evaluation design in response to CMS feedback. The revised plan was submitted to CMS on March 9, 2016. On May 17, 2017 DHS received additional comments from CMS. The evaluation plan was revised and submitted on June 22, 2017.

13. State Contact

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Home and Community-Based Services Partners Panel Meeting February 15, 2019

9:00 a.m. – 12:00 p.m.

Hi-Way Federal Credit Union Admin Office
840 Westminster Street
St. Paul MN 55103

Agenda

Time	Agenda Item	Speaker
9:00 – 9:10	Welcome, Introductions	Aron Buchanan, *facilitator, Aging and Adult Services Division*
9:10 – 9:45	Reform 2020	Jan Kooistra, *Federal Relations, Health Care Administration*
9:45 – 10:30	CM Redesign	Jennifer Blanchard, *Director, Community and Care Integration Reform, Health Care Administration* Lisa Cariveau, *Case Management Redesign Lead, Health Care Administration*
10:30 – 10:40	BREAK	
10:40 – 10:55	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*
10:55 – 11:55	HCBS Access Project	Sara Galantowicz, *Project Director, Abt Associates*
11:55 – 12:00	Announcements Closing	Panel members Aron Buchanan, *facilitator, Aging and Adult Services Division*

DEPARTMENT OF HUMAN SERVICES
HOME AND COMMUNITY BASED SERVICES PARTNERS PANEL

Tentative Meeting Schedule for 2019

Third Friday of every other month (EXCEPT AS NOTED), 9-noon

Date	Location
February 15, 2019	Hi-Way Federal Credit Union Admin Office 840 Westminster Street St. Paul MN 55103
March 22, 2019 (NOTE: This replaces the April meeting and is on the fourth Friday)	Dakota Co. Northern Service Center, Room 110 A/B 1 West Mendota Road #100 West St Paul, MN 55118
May 31, 2019 (NOTE: This replaces the June meeting and is on the fifth Friday)	Hi-Way Federal Credit Union Admin Office 840 Westminster Street St. Paul MN 55103
August 16, 2019	Hi-Way Federal Credit Union Admin Office 840 Westminster Street St. Paul MN 55103
October 18, 2019	Hi-Way Federal Credit Union Admin Office 840 Westminster Street St. Paul MN 55103
December 20, 2019	Lutheran Social Services 1605 Eustis Street St. Paul MN 55103 Room Weiser A and B

If you are attending remotely, the session will be presented via WebEx. You can use your computer or phone for audio:

Join the meeting via WebEx

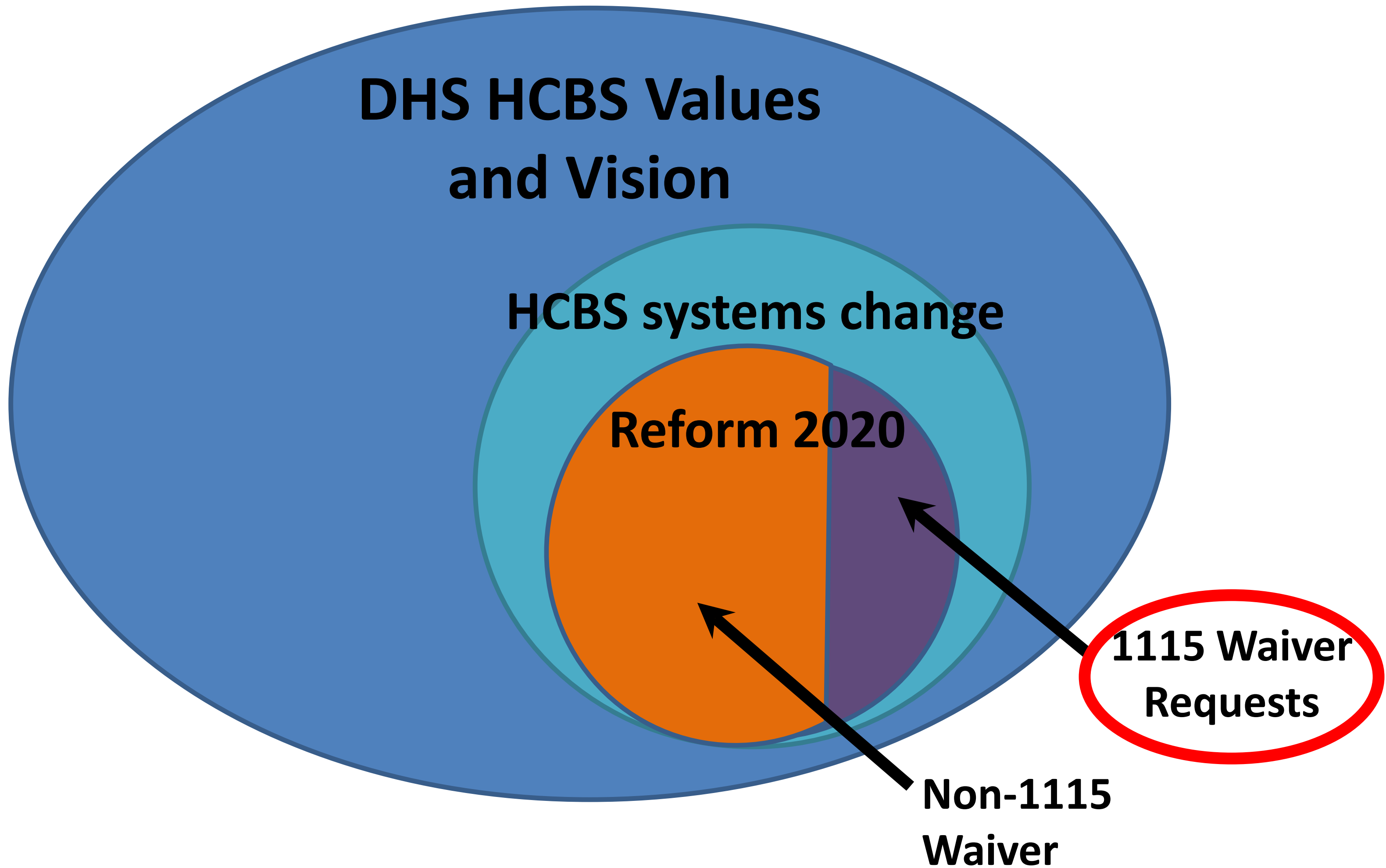
- All callers: 844-302-0362 (US Toll Free)
- Conference ID/Access code: 595 395 320
- When prompted, press #
- You will also be asked for an attendee ID which is unique to your WebEx session and can be found after you sign in to the WebEx.

REMEMBER, IF YOU ARE PHONING IN—DO NOT PUT YOUR PHONE ON HOLD! DOING SO SUBJECTS EVERYONE ELSE TO LISTEN TO MUSIC

Reform 2020 Section 115 Waiver: Annual Public Forum

Jan Kooistra, Health Care Administration
Cara Benson, Disability Services Division
Rachel Shands, Aging and Adult Services Division
February 15, 2019

Orientation to Today's Discussion



Section 1115 Waivers

Section 1115 of the Social Security Act allows states to waive certain requirements under Medicaid or use Medicaid funds in ways that are not otherwise allowed under federal rules

- Demonstrate new policy or delivery approaches that promote the objectives of the Medicaid program
- Must be budget neutral to the federal government over course of waiver
- State must conduct an evaluation and report on demonstration outcomes

Reform 2020 1115 Waiver

- Federal support for the ***Alternative Care Program***
  - Status:
    - Receiving Federal Financial Participation
    - Implementing required evaluation

- Federal authority to expand access to the ***Community First Services and Supports (CFSS) program*** for people not otherwise eligible
  - Status:
    - Withdrawn from Reform 2020 waiver in March 2018
    - Implementation will require federal authority via state plan amendment
    - DHS plan for CFSS implementation continues

Reform 2020 1115 Waiver, cont.

- Approved by the Centers for Medicare & Medicaid Services through June 30, 2018

- Minnesota's request to renew for another three-year period, through June 2021.

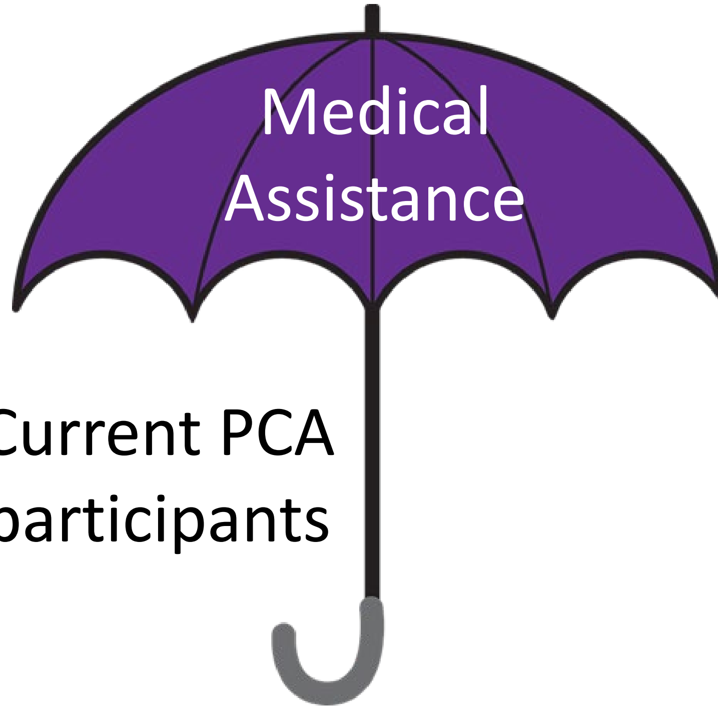
- Currently operating under temporary extension through March 31, 2019

Updates: Who is covered under CFSS?

Short Answer

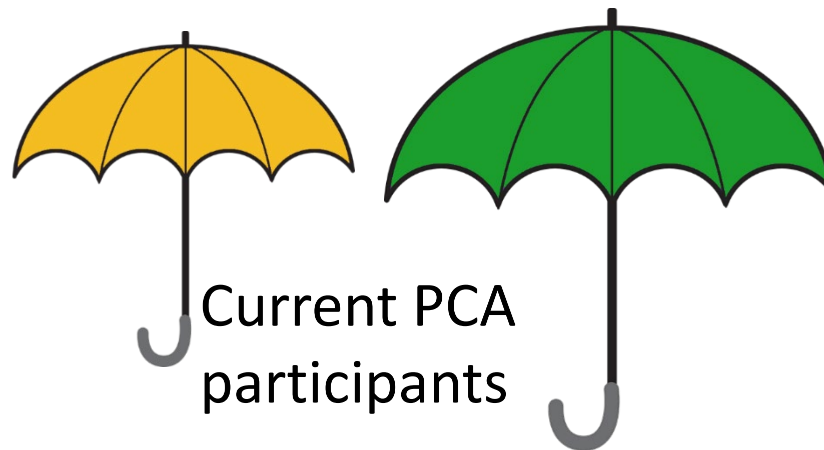
Eligibility for CFSS will be the same as eligibility for PCA.

Currently . . .



To offer CFSS, initially we needed to . . .

Due to population shifts because of the ACA . . .



Alternative Care Evaluation

- Compare the AC population before and after November 1, 2013 when the waiver was implemented, and compare the AC population to the Elderly Waiver population before and after November 1, 2013.
- Evaluation looks at:
  - Level of need, demographic characteristics, and service use patterns for AC and EW over time
  - Use of and access to consumer-directed options
  - Length of time in the community compared to NF use
  - Use of Essential Community Supports, a program designed to serve seniors with emerging needs for community support

Evaluation, continued

- Outcomes will be examined for AC participants alone, and in comparison to Elderly Waiver participants
- DHS expects the evaluation to show that AC participants have equal or better outcomes, compared to the pre-demonstration AC program
- Evaluation provides DHS an opportunity to examine outcomes for both AC and EW populations with a analytic, research-based approach.
- Understanding better how these programs support older Minnesotans will help DHS to respond to expected increase in demand for services as the population of people age 65 and older grows

Examples of Interim AC Evaluation Findings

- Trends in the AC program show consistent patterns pre-demonstration and since the implementation of the 1115 waiver
- The demographics of AC participants changed very little from 2012-2015.
- The use of CDCS services among AC participants increased from 3% in 2012 to 5% in 2015. Only 2% of EW participants were using CDCS services each year.

Future Activities

- Annual reports to CMS on the progress made in implementation of the evaluation plan.
- Additional repeated analysis at points in time (snapshots) will add more statistical analysis
- Follow groups of people or cohorts over time to look at outcomes related to NF admission, mortality, length of time in the community.
- Final report at the end of the waiver approved period.

Opportunity for Public Comment

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?
A: The slides were emailed out to everyone, but all materials from the meeting will be posted the HCBS Partners Panel web page.

Q: Will we get the slides for this after the meeting?
A: The slides and HCBS Access overview handout were emailed out to everyone prior to the meeting. While all materials from the meeting are normally posted the HCBS Partners Panel web page, because the information in the detailed PowerPoint contains preliminary data, it is not posted online but rather is available upon request from Mary Olsen Baker at mary.olsen.baker@state.mn.us or Julie Angert atJulie.angert@state.mn.us.

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 identity 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

Analysis of Adult Maltreatment Reported for AC Participants

(01/01/2019 - 03/31/2019)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 01/01/2019 and 03/31/2019
Determinations limited to those made between 01/01/2019 and 06/17/2019

CEP- Reported Adult Maltreatment Involving AC Participants
(01/01/2019 - 03/31/2019)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 6/17/2019	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional/Mental Abuse	12	6.67%	2	5.41%	2	0	0.00%
Physical Abuse	8	4.44%	4	10.81%	4	0	0.00%
Sexual Abuse	1	0.56%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	9	5.00%	4	10.81%	3	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	31	17.22%	5	13.51%	3	0	0.00%
Caregiver Neglect	35	19.44%	11	29.73%	7	0	0.00%
Self-Neglect	84	46.67%	11	29.73%	7	3	11.54%
Total	180	100.00%	37	100.00%	26	3	11.54%

Source: DHS Data Warehouse 06/17/2019 (this should be at least 3 mos 10d following end of waiver reporting period.)

Dispostion of County Investigations of Maltreatment Allegations Involving AC Participants
CEP Reported Allegations : 01/01/2019 and 03/31/2019

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional/Mental Abuse			1	1	2
Physical Abuse				4	4
Sexual Abuse					0
Fin. Exploitation (Fid Rel)		1	1	1	3
Fin. Exploitation (Non-Fid Rel)		1		2	3
Caregiver Neglect		4	2	1	7
Self -Neglect	3	3		1	7
Total	3	9	4	10	26

* Includes No Determination: No Maltreatment
^ Includes No determination - Not a Vulnerable Adult

Source: DHS Data Warehouse 06/17/2019 (this should be at least 3 mos 10d following end of waiver reporting period.)