

- SPONSOR GROUP -
MANAGING SERVICES FOR PEOPLE WITH DISABILITIES

**MEETING MINUTES February 16, 2006, LOCATION: DHS/ANDERSON
BUILDING**

I. IN ATTENDANCE:

- i. **Participants From Counties:** *Margaret Langfeld, Anoka County Commissioner (Sponsor), *Amy Wilde, Meeker County Commissioner (Sponsor), *Tom Henderson, Brown County HS Director (Sponsor), *Dave Rooney, Dakota H.S. Director, (Sponsor), Patricia Coldwell, AMC staff/Task Force Lead Staff, Dan Papin, Washington County HS Director, Jerry Soma, Anoka County HS Director and Kay Dickison, LPHA/Dakota County.
- v. **Participants From DHS:** *Brian Osberg, DHS Assistant Commissioner (Sponsor), *Wes Kooistra, DHS Assistant Commissioner (Sponsor), *Christine Bronson, DHS Medicaid Director (Sponsor), Char Sadlak, Michelle Basham, Pam Parker and Pam Erkel.

*Denotes Sponsors

II. Introductions & Announcements:

- a. **Agenda Changes:** The MHAG presentation will precede the presentation concerning the federal budget reconciliation act.

III. MHAG update – Wes Kooistra:

- a. **Overview of the Mental Health Payment Model** (*See handout*): Opening comments recognizing organizations that contributed to process. Very open process, the Department sought feedback from groups including providers, health plans and counties. Statement made that what we have now has intentionally been left somewhat open in order to leave room for comments. Pages 1-3 provide background for the process and the principles for MHAG. This process started with a Governor's order giving MHAG assurances to proceed in their work.

Various comments were raised regarding specific parts of the proposed model: (*also see page four of the handout.*)

- Continue incorporation of the model benefit set by adding MA services paid with county and federal funds into all publicly funded health care programs: With 87 different counties there will be varying levels of satisfaction with this proposal. Enrollment in preferred integrated care networks will be phased. "Preferred" meaning that

social services and care would be integrated and plans that are chosen would have to integrate mental health, social service and health care. Department also hopes plans will be special needs plans or SNP's.

- Persons in prepaid health plans would receive case management or care coordination through the party responsible for integrated mental health and physical health care: How does Department see variations between counties of waived services? In response, the Department stated that it does not address the waiver system in this proposal. In addition, the Department is not trying to limit client choice but to see integration of services and sees counties as critical to this process. Comment made that there are two conflicting choices: "choice and integration." The Department responded that we will develop an RFP that goes to these concerns including county connections/relationships. Question raised regarding last four words on page 5: "*and other social service entities.*" Department response that there is no specific type of entity envisioned in those words. "Other social service entities" could take a variety of forms. It goes beyond day to day social services but also controlling risk. Question clarifying that the counties would still be responsible for social services and therefore, would the health plans have funds to cover this service delivery? The Department responded that what we are trying to do is to have money follow responsibilities.
- Procurement and Contracting Standards: We will develop fairly rigorous standards in the contracting process for relationships with counties and performance measurement. Concern raised by county participant that health plans have different motivators than counties. The Department responded that there will be a common benefit set that all plans have to provide. Additional concern raised that we need to have specification in RFP's to address medication prescriptions and monitoring. General comment by Department that we need to remember that whether we do anything or not, the challenges remain. A county urged the Department to think about risk management sharing between the counties and the plans. In response, the Department reiterated that we will build into the RFP and procurement process the issues of risk management and working with the counties. Overall, this proposal moves care coordination and risk management into the same system. Current enrollment: we have about 90,000 duals and about half are in managed care and half are in fee-for-services. Of the managed care enrollees, about half are in MnDHO and half are in other managed care plans.
- Other Comments: Crisis intervention and stabilization- we have to figure out how to pay those that are not covered to make this viable. Improving reimbursement for mental health professionals in exchange for increased access (disproportionate share strategy.) Timely access

for psychiatric care beds and acute care beds. There are a variety of reasons why clients are backed up in these beds and very often it comes down to resources. Evidence based practices including an expansion of the “Hawaii” project. The Department recognizes and will build in start- up costs. School based and treatment and an attempt to shore up some of the losses in Title IV-E. Specialty services such as eating disorders and attachments disorders. In addition, this includes culturally specific services.

- Items 2, 3 and 4 of page 8 assume county maintenance of effort (current mental health systems): These items reference county share. Currently, there is no incentive for moving clients through the system but this proposal responds to that. Question asked what about employment services and where it fits in proposal. The Department responded that it probably needs to stay where it is. Generally, the Department also stated that in order to make these changes, we would have to revisit roles and the Mental Health Act. Comment made that there may be a plethora of state laws we need to reexamine in light of this (for example: vulnerable adults act, commitment act etc.) Comment made that before this proposal is implemented, we should figure out how the care coordination between the counties and the plans is going to work. The Department responded that rather than being linear, we need to start somewhere and of course, if there are problems along the way we will address them but the system as it is, is not working so we need to start somewhere. Additional question raised concerning data sharing and HIPAA as additional issues that will need to be addressed. Department responded that there are procurement vehicles in place for data sharing and responding to the concerns.

IV. Federal budget reconciliation act update – Christine Bronson.

- a. SUMMARY (See handout): Overall comment made that we need to clarify when these provisions take effect. Question raised concerning state & county roles. Department responded by asking question whether during March 3rd 2006 Task Force meeting we should we have a broader discussion including how the passage of the deficit reconciliation act will impact human service delivery and state & county roles. Generally, positive response that we should do this. Additional comment made that it would be helpful if state provided language that counties could bring to discussion in Washington. The Department volunteered to preview language the counties would bring to Washington.
- CONSENSUS: We will take the conversation back to a broader level on March 3rd, particularly in light of how DRA changes the framework of the conversation or the priorities of the Task Force. Point raised- can the state and the counties work together to respond to this

challenge legislatively? Or, in the alternative, can we at least share information between the state and the county concerning the impact of the DRA? Question left somewhat open but generally, the impact of DRA will be discussed at the March 3 meeting.

V. Presentation of detailed work plan.

- a. Discussion:** We should not try to merge/treat all three sub-groups the same and we should make sure we are connecting any internal DHS groups with MACSSA groups and be aware of county data that has been prepared. We also may want to discuss once we finish the baseline question whether we need workgroups.

VI. “Baseline” Question:

- a. Discussion:** Discussion about the lack of data specifically on people with disabilities. There is some data contained in MnDHO evaluations and data which includes but is not limited to people with disabilities in other studies. Suggestion made that we do survey on people with disabilities.

VII. Inventory of “What’s” & Current Model (what works/doesn’t work).

- a. Discussion:** We will need to flesh out how critical service integration is, including waived services and what level of integration? We need to address integration with Medicare Part D. We need to add simplicity for consumer: can the consumer understand and easily navigate the system? We should add “federal permissibility.” We should categorize the topics under “what’s.”

VIII. Next meeting dates/session (week of April 10 and last week May): Some members expressed hope that we will meet again within the next few months. One possibility discussed was a meeting during the one week session break (week of April 18th, 2006.)

- a. Follow Up:** Decide when to have next meeting and send notice to members.