

- SPONSOR GROUP -
MANAGING SERVICES FOR PEOPLE WITH DISABILITIES

MEETING MINUTES NOVEMBER 28, 2005
LOCATION: AMC

I. IN ATTENDANCE:

a. Participating Members From Counties:

- i. *Amy Wilde, Meeker County Commissioner (Sponsor)
- ii. *Tom Henderson, Brown County HS Director (Sponsor)
- iii. Patricia Coldwell, AMC staff/Task Force Lead Staff
- iv. Kate Lerner, MACSSA staff
- v. Jerry Soma, Anoka County HS Director
- vi. *Dave Rooney, Anoka County Community Services Division Director, (Sponsor)
- vii. MayKao Hang, Ramsey County Director Adult Services
- viii. Kay Dickison, LPHA/Dakota County
- ix. Julie Ring, LPHA Director

b. Participating Members From DHS:

- i. *Brian Osberg, DHS Assistant Commissioner (Sponsor)
- ii. *Wes Kooistra, DHS Assistant Commissioner (Sponsor)
- iii. *Loren Colman, DHS Assistant Commissioner (Sponsor)
- iv. *Christine Bronson, DHS Medicaid Director (Sponsor)

c. Staff Members From DHS:

- i. Char Sadlak
- ii. Michelle Basham

*Denotes Sponsors

II. APPROVAL OF MINUTES FROM OCTOBER 20TH MEETING: Note made
Minutes approved without changes.

III. FINALIZATION OF WORK PLAN AND TIMELINES:

- a. General:** Brian Osberg made group aware of parameters for timeline if group tries to come up with some type of legislative proposal.
- b. Group Goal Discussion:** To help inform each other about process and strategy. Strategies could be used for legislative. Not necessarily a shared proposal but something that both the county and the state can live with. Brian Osberg stated that in his mind this group would help inform DHS proposals to the Governor's office.

c. **Comments About Proposed Amendments to Timeline (see *handout*):** Comment made that meeting once every other month might not be enough to get all of the work done. We might need to think about additional workgroups and/or meeting more often. One member responded that comment made sense. For example, just this week someone had also raised the issue that we might need to bring elderly services work into this committee.

d. **Comments About Name:** *Managing Services for People with Disabilities* instead of *Managed Care for People with Disabilities*.

IV. UPDATED MATERIALS ON CASE MANAGEMENT:

a. **Follow Up from Last Meeting/County by County Information On Case Management:** Char Sadlak reported that she has obtained requested information on county by county case management costs from DHS Finance and Management Division (*See back of binder.*)

i. **Discussion:** Member asked whether this information included information on targeted case management.

ii. **FOLLOW UP:** Provide county by county breakdown information concerning targeted case management.

V. UPDATE ON FEDERAL BUDGET RECONCILIATION ACTIVITY (CHRISTINE BRONSON):

a. **Targeted Case Management:** (*see handout*) The house has passed its proposal off the floor. The house proposal includes severe restrictions on what targeted case management service options states can provide. The proposal also represents a cut of \$86 million per year in targeted case management and an additional \$35 million if the bill is intended to target home and community waived services.

The proposal has been promoted as only placing limits on states in providing case management services but Minnesota's reading of the language is that, it will in essence eliminate case management.

i. **Discussion:** Member asked what type of work is being done to change proposed language and its impact on targeted case management. Response that targeted case management does not have an automatic appeal/sympathy but the state is trying to educate house/senate staff about the potential impact of the proposed cuts. Additional comment that we need to think about how this will impact the work of this group. Additional note that our targeted case management is currently under audit.

Regardless of the result of legislative proposals, we should recognize the federal signs of policy direction: even if targeted case management was not eliminated now as a result of this proposal, it looks like case management is falling out of disfavor as a model.

- b. Third Party Recovery:** States are concerned because the way the language is worded, the proposal puts other services in the position of funding Medicaid first. Reverses who has to pay first. DHS has pointed out to senate staff that the current language would make other programs primary to Medicaid.
- c. Restructuring Medicaid Pharmacy Programs:** Four points to think about - -
 - i. Locking in federal upper payment limit.**
 - ii. Dispensing fees.**
 - iii. Rebate Issue:** Increasing amount of rebate that states can collect.
 - iv. Anti-psychotic and psychotropic medications provision:** Minnesota advocates limiting restrictive language on when a state may require prior authorization. As long as states are acting according to formularies, they should have flexibility to look at responsible cost savings measures.
- d. Long-Term Care Reform:** DHS supports, essentially represented in our waiver program.
- e. LTC Partnership:** DHS supports these provisions as well.
- f. Hurricane Katrina Provisions:** DHS is hoping the provisions will not be limited to Medicaid recipients.
- g. Reduction in Payments to Nursing Homes.**
- h. Revising SCHIP Funding.**
- i. Generally:** We hope that someone intended to fix problems (that states could get third party recovery from a health plan) and that the language of the bill was just not tight enough and that they will be willing to modify the language.

- j. **Other Funding:** There is legislation pending that would cut Title IV-E for child protection services. The language would reduce the types of kids who could be viewed as “at-risk” for foster care. Also places limits on kinship placements.

VI. THE COUNTY SYSTEM OF SERVICE DELIVERY (TOM HENDERSON AND MAYKAO HANG):

a. MayKao Henderson:

- i. **Adult Services in Ramsey County** (see handout): Basically Ramsey County Human Services has four different areas: family & children’s services, adult services, administrative services and financial assistance services. Some of the areas have cross over (for example young adults who are transition age, kids on CADI and DD). The services in adult services include services such as: supportive housing and housing supports, case management, crisis services (Detox and mental health), residential treatment services with in-home based care (example-PCA services). Counties serve, along with the State, as the safety net for the vulnerable and disabled, providing care for low income and indigent residents. In the past four years, counties have had to cut early intervention and prevention programs due to budget shortfalls, leaving a gap in many services.

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ii. Roles of County:

- 1. **Quality Assurance and Safety Net:** Auditing and evaluation of service delivery.

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- 2. **Purchaser of Social Services:** Buyer of services/contract manager of community-based services. For example-in the mid to late 1990’s, a need emerged to serve elder Hmong people and the county contracted with providers to respond to this need.

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- 3. **Provider of Direct Services.**

- 4. **Identification/Maintenance of Social Services Continuum of Care:** Ramsey County has a planning group with county and community based vendors who plan for and respond to community needs and emerging social service trends. The county also provides technical assistance and acts as a bridge to nonprofit providers.

a. **Comments:** Concern raised about comment that if case management for elderly is converted to managed care and/or privatized, it will make it difficult for county to play a larger planning and quality assurance role. This is true, as counties are no longer part of the delivery system. They lose ownership and ability to provide planning, quality assurance, technical support, and ability to maintain a provider network for seniors.

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iii. **Appeals:** County is primary coordinator of all appeal issues, mostly social service appeals but in Ramsey, assistance is also given to those who need help to appeal to the Social Security Administration for benefits that have been denied due to inability to demonstrate a disability.

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b. Tom Henderson:

i. **History:** Back to state hospital days and before, many disabled people never left their homes. When Tom came to Brown County, there were a lot of people, for various reasons, with varying disabilities. Into the 1950's, as the population increased, the rate of inter-family relationships decreased and so did the rate of disabilities. At the same time, many people were sent to state hospitals if they were arbitrarily deemed to be suffering from a disability. This trend continued until the 1960's when the de-institutional movement started. Despite the move to bring people out of institutions, there were very few services available to help people transition back into the community. In the 1970's, Brown County acquired its first "sheltered workshop" program. The first program was located in New Ulm. Through 1980, they only had one kind of provider- a mom and pop operation until they identified a second provider that was an organization. About another 15 years later, the community trend was to have in-home care as an alternative to the group home model. In response, Brown County identified a third provider leaving them with three options: the mom and pop operation, the group home and the in-home care model. The state is also organized around regionalized centers which coordinate service delivery.

ii. **Current System at Brown County:** They have about 15 case managers. In rural areas, the nonprofit options are

much more limited. They do have a hospital with mental health services and a mental health center. Rural counties tend to take a lot of ownership in disabled groups. They have a substantial United Way organization.

They also coordinate about 50 contracts per year with community based organizations. They have a lot of community integration efforts for providers. The county also manages a transit system that provides about 5,200 rides per month. This service is an example of a county developed and run service in response to the needs of disabled people who were deinstitutionalized into the community.

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As far as appeals, they recently lost a decision (Region 9) that caused all of the Region 9 counties to develop some new policies for DD waivers that would work for all of the counties. The South Country Health Alliance wants to see a pretty substantial increase of case management services and they are trying to respond to that.

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1. **Comments/Discussion:** Comment by DHS member that we should focus on the “what” instead of the “who” and the needs of clients who may cross program boundaries in order to envision the best potential new model to serve clients. Additional comment that in some ways counties have more options than they used to. One member raised the concern that could loose what we are doing while we learn or reshape the service models. We may not be able to learn and develop meaningful program changes because changes might be coming from powers above us whether we like it or not and coming quickly.
2. **Case Management:** Question about how waived case management services are provided. County member responded that most are provided through social services but some are provided through public health. Generally, it depends on where the emphasis is (health needs or social service needs.)

VII. MANAGED CARE VS. FEE FOR SERVICES (**BRIAN OSBERG**):

- a. **Managed Care:** (see handout in binder/maps.) First map details PMAP health plan contacts for state of Minnesota. Second map identifies health plan contacts by county. Our plans have to be

actuarially sound. There is an 8-11% percent withhold for administrative overhead. Three indicators for provider incentive: lead testing, well child visits and dental visits.

- i. **What We Buy:** Risk, claims payment, third party recovery, federal and state requirements, health care services, provider network (assures access to our clients OB-GYN) and accountability. With utilization, sometimes we purchase more support services to save money on institutional care.
- ii. **Comments:** We might want to look at some existing models for how to set something up instead of starting from scratch because the cost of setting up the infrastructure/protocols can be fairly cost prohibitive. A county member also raised the question whether the state is going to pay the health providers to develop their own protocol or require sharing so we are not duplicating payment of costs to develop a protocol. Another member raised the question of how much “choice” do the feds require when they require “choice?” Peripheral to this issue, to what extent do we have to have “permission” from CMS to change our model?
- iii. **Issues:**
 1. Who do we hold accountable for what and how do we judge accountability?
 2. How do we hold the provider network accountable?
 3. How do we get financial as well as program outcome accountability?
 4. **NOTE FOR FUTURE MEETINGS / TO BE REVISITED:** To what extent does client choice drive county based purchasing or more of a managed care model?
 5. **NOTE FOR FUTURE MEETINGS:** Health disparities are a growing issue we should be looking at in addition to keeping cultural competency in mind.

b. Elements of Managed Care: *(see handout.)*

- i. **Assumption/Management of Financial Risk:**
Capitation/full risk.

- ii. **Administrative Services:** Includes claims payment, enrollment process/issuance of cards, third party recoveries and meeting regulatory requirements.
- iii. **Provider Network Development/Management:** Access and accountability.
- iv. **Medical Management:** Case coordination, disease management and quality improvement.
- v. **Health Promotion/Wellness.**

c. **Minnesota's Fee for Service System:** *(see handout)*

VIII. **DISCUSSION OF TOMORROW'S TASK FORCE PRESENTATION:** Brian Osberg will present.

IX. **SET DATES/AGENDA FOR NEXT SEVERAL SPONSOR MEETINGS:** The sponsor group will probably meet at least two more times before the next task force meeting (maybe January and February.)

X. **OTHER?**

- a. **Update on Advisory Committee:** DHS is going to ask for extension on January 01, 2006 legislative deadline and wanted to run that by group.