

Conflict Free Case Management Meeting Minutes

Meeting Date	2/19/2013	Meeting Leader	Nova York
Meeting Time	10:00 AM	Meeting Scribe	Misty Jenkins
Meeting Location	Webinar	Next Meeting	Undecided

Attendees:

Nova York	Misty Jenkins	Paulette Johnson	Ashley Lacoste
Sherri Gardner	Ann Ricks	Kristi Plotner	Shannon Spooner
Tracy Mulholland	Elizabeth Caldwell	Joshua Bankston	Sandra Bracey
Robin Cooper	Margaret Brim	Sandra May	Mason Smith
Tracy Malone	Wendy White	Ed Kako	Teresa Shoto
Kenneth Dowden	Tressa Eide	Lee Horton	Nita Durrell

Agenda:

- A. Discussion – Webinar led by Missions Analytic Group. They presented a power point on the new (last week) CMS guidance on Conflict Free Case Management. After the presentation, there was a brief Question and Answer period facilitated by Robin Cooper from NASDDDS.
 - a. Nova brought up the issue that the current HCBS Waivers do address much of what CMS is looking for and asked for feedback from DOM on what they thought was not meeting the guidelines in the waivers. Kristi Plotner and Ann Ricks agreed that the waivers do cover quite a bit already but could be strengthened in this area. It seemed that the major conflicts were within the LTC options outside the waivers.
 - b. Robin Cooper asked about how CFCM was addressed in the Rehab Option and Kristi acknowledged that we had difficulties in this area.
 - c. Nova York broached the idea of whether we should include consumer involvement in determining where there were conflicts and Robin Cooper agreed that we should and referred us to the National Core Indicators site: <http://www.nationalcoreindicators.org/indicators/> to prompt our thinking on measures MS could consider for monitoring consumer experience. The group discussed the possibility of the CFCM group creating a Performance Measurement tool by using the National Core Indicators to create an assessment for beneficiaries/ consumers as to their satisfaction and for feedback.
 - d. Kristi Plotner stated that while there is more visible conflict for the PDD’s as they are private entities, it is eased by the fact that DOM handles approval/denial. She also stated that providers should case manage more than just the services that their agency/waiver offers to assist clients with outside/non-waivered services.
 - e. Mission noted that CMS is understanding in regards to the fact that some areas are very rural and may not be able to totally eliminate conflict but that their goal is to see states establish firewalls and goals to move toward less conflict.
 - f. Robin Cooper finished up by stating that CMS is looking for a “meaningful” approval process, where the agency determining eligibility is really looking at the plans of care to determine whether there is conflict.
 - g. “Vendored” Case Management was discussed and defined.

- B. Conclusions
 - a. DOM will review our group notes from the last week or two and provide more feedback.
 - b. Our group really needs to delve into the non-waivered LTC options.

C.

Action Item	Person Responsible	Completed/Needs to Be
Send out Power Point and Core Indications Link	Mission Group	Completed

Conflict Free Case Management Meeting Minutes

Meeting Date	4/4/2013	Meeting Leader	Nova York
Meeting Time	10:00 AM	Meeting Scribe	Donna Dungan for Misty Jenkins
Meeting Location	Conference Call	Next Meeting	April 18, 2013 1:00-3:33PM Conference Call

Attendees:

Nova York	Donna Dungan	Paulette Johnson	James Masters
Amy Bishop	Ann Ricks	Elizabeth Caldwell	Aurora Baugh
Tracy Mulholland	Sandra Bracey	Betsy?	

Agenda:

- a. If we did a survey, would the stakeholder group have to mail it out and compile the results? No, DOM would have to send out the survey due to beneficiary information and HIPPA.
- b. It was discussed that instead of sending out a survey, we propose that the appropriate questions be asked during DOM Yearly Audits. Even 2% consumer involvement is a large representation of the population.
- c. Clients SHOULD be able choose who provides their in home services from a list of providers (over 20 for homemaker services).
- d. The discussion turned to choices in mental health. According to James Masters (Mental Health), they DO have a grievance procedure and he will get it to the group via Nova.
- e. The group discussed the limitations of the regional nature of the Mental Health/IDDD services. Perhaps allowing clients to choose from providers in other regions is the answer? Per the conversation, this would be very difficult and chaotic.
- f. There are policies already in place on the waiver programs, so could one policy resolve the CMS requirement?
- g. The next stakeholder meeting is May 21st from 2:00-4:00 at the Woffolk Bldg. Downtown.

B. Conclusions

- a. We have evolved away from the idea of surveying consumers.

C.

Action Item	Person Responsible	Completed/Needs to Be
Provide documentation of DMH grievance procedures.	James Masters	

Conflict Free Case Management (CFCM) Learning Collaborative Group Recommendations:

CMS guideline 1:

Clinical or non-financial eligibility determination is separated from direct service provision.

This goal was met within 4 of the Waiver Programs with the implementation of the Pre-Admission Screening Form (PAS), which uses a scoring algorithm to determine physical eligibility for LTC services. Within this system, detailed assessment information is gathered by the screener, be that Case Manager, admission personnel within a facility, or Support Coordinator and this information is systematically analyzed in the exact same way for every client, thus determining eligibility. This method removes clinical eligibility determination from direct service provision for these programs and allows for eligibility determination to be based distinctly from the provision of services perspective, not from the best interest of the screening organization perspective. This separation applies to both initial screenings and re-determinations.

Similarly, the Intellectually Disabled/ Developmentally Delayed (ID/DD) Waiver and Mental Health LTC services programs use pre-formulated assessment tools, which are directed at these specific beneficiary populations to determine clinical eligibility. These assessment tools are not driven by a numerical scoring system, but allow for systematic gathering and entering of information in the same manner for all beneficiaries, thus removing "screener bias" which may affect the number of beneficiaries deemed eligible.

Appropriate firewalls are in place within Medicaid policy to ensure appropriate use of the PAS (see attached Waiver policies, which address Division of Medicaid responsibility for home visits to assess screener use of the tool). For the ID/DD Waiver, firewalls are also in place via the Department of Mental Health (DMH) Operational Standards which state that ID/DD Waiver Support Coordinators cannot also be direct service providers. In the Community Mental Health Centers it can be the same person who makes the eligibility determination and provides the services. This would be true in individual therapy situations when part of a therapist's job is to diagnose. The two are inextricably entwined.

Recommendation: No changes.

CMS guideline 2:

Case Managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to any one financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.

Recommendation: The CFCM Group recommends the adoption of a formal policy for all LTC programs restating the CMS guideline 2.

CMS guideline 3:

There is robust monitoring and oversight.

See attached CFCM policies currently in effect for Medicaid LTC Waiver Programs. Numbers 4, 5, and 7 pertain specifically to the current DOM audit and home visit policies. These practices include monitoring and assurance of screener use of the tool to determine eligibility as well as oversight of general Case Management activities, including response to problem solving within the program. Reviews of CMHCs also contain a monitoring and oversight component, but these components are not operated exactly like the waivers.

Recommendation: The CFCM Group recommends that current policy be expanded to include auditor review of free choice of provider and client satisfaction with Case Management activities. These items can easily be incorporated into the existing home visits currently being conducted by DOM personnel by expanding the items which are addressed by the auditor while performing the home visit. In any instance in which a client reports not being given freedom of choice of providers or conflict within the Case Management function, the DOM would address the Case Management provider, review the resulting investigation, and over see an acceptable resolution.

CMS guideline 4:

Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision, and outcomes.

Currently, the client receives certified notification when any service is denied, reduced, or terminated. This notice offers clear instructions on the way in which consumers can appeal a service based decision. Also, the consumer receives a copy of their Bill of Rights and contact numbers for their Case Managers or Support Coordinators on admission. Number 3 of the attached policies list includes formal policy for Fair Hearing and Appeal. Within the Mental Health system, the Consumer Grievance Policy is clearly posted within the Mental Health offices and clients are given a Consumer Grievance Form in their initial enrollment packet and annually thereafter. The DMH also has a process for appealing decisions. This process is listed in the Waiver document.

Division of Medicaid policy clearly outlines the responsibilities of the provider, client, and Division of Medicaid along with time lines when a grievance is submitted or a problem is reported.

Recommendation: The CFCM Group recommends that the DOM include in formal policy a list of those items which are to be given to each beneficiary at the time of admission and re-determination. Items to be given to the beneficiary include Case Manager or Support Coordinator names and contact numbers when assigned, contact number for the direct provider's Supervisor, a list of providers currently providing services in the client's home and their contact numbers when they are chosen by the beneficiary, instructions for reporting a problem or grievance, a copy of the client's Bill of Rights, and any other information deemed necessary by the Division of Medicaid (HIPAA policy, Emergency Preparedness Plan, etc.) If new forms are developed for this purpose, service providers should be allowed to give input on the development of the forms to be used. For example: DMH has its own Individual Rights form that is used across DMH programs (IDD, A&D, MH). DMH will ensure all elements of the DOM Bill of Rights are in the DMH Individual Rights but do not want a different form for Waiver recipients. The same is true for CMHC services. Additionally, the DMH operates a grievance system for all of its services.

CMS guideline 5:

Grievances, complaints, appeals, and the resulting decisions are adequately tracked and monitored.

Currently each of the Waiver Assurances in the attached example outline the actions of the Division of Medicaid when non-compliance is noted or a grievance/appeal request is received. These detailed actions meet the above standard by outlining specific steps to be taken in order to reach a successful resolution should a problem arise. DMH has an extensive system to address grievances, from anyone who receives services from the DMH, not just the ID/DD Waiver and CMHCs. This process is in the approved ID/DD Waiver and the DMH Operational Standards.

Recommendation: No changes.

CMS guideline 6:

State quality management staff oversees clinical or non-financial eligibility and service provision business practices to ensure that consumer choice and control are not compromised, both through direct oversight and/or the use of contracted organizations that provide quality oversight on the State's behalf.

Currently, the audit schedule and home visit schedule listed in numbers 1, 2, 4, 5, 6, 7, 8, and 9 of the attached policies all address and adequately meet the requirements of this guideline. Also, the Division of Medicaid staff reviews 100% of initial and re-determination applications and Plans of Care from the physical eligibility and service provision stand point, which further meets the requirements of this guideline.

DMH makes the determination for initial and ongoing eligibility and approval of the Plans of Care for the ID/DD Waiver. DOM has access to the information at all times to be able to review decisions. DOM gathers information about consumer choice and control via its OSCR process. Additionally, DMH contracts with the Arc of MS to conduct Personal Outcome Measures™ for all of its services. Data from the National Core Indicators for the ID/DD Waiver is being gathered and will be available for review next fiscal year.

Recommendation: No changes.

CMS guideline 7:

Track and document consumer experiences with measures that capture the quality of care coordination and case management services.

Each Long Term Care Program currently gathers information for monitoring client satisfaction with quality of care and case management services. However, the methods used vary: Waivers have used Supervisory visit forms, while DMH contracts with the Arc of MS to conduct Personal Outcome Measures™ for all of its services. Additionally data for the National Core Indicators for ID/DD programs is being gathered and will be available for review next fiscal year.

There does appear to be some inconsistency in the way in which this information is gathered, tracked, and used to affect future LTC actions.

Recommendation: The CFCM Group recommends that the DOM further expand the use of its home visit schedule to address quality questions. As stated in recommendations for CMS guideline 3, these items can easily be incorporated into home visits already being performed to gather information about PAS use. Once obtained, the information can be organized in a fashion which allows the DOM to track any negative trends which emerge based on the number and types of client responses and respond to these on a statewide basis. Adequate documentation of the questions used to gather the information, the number and type of responses, and the DOM actions in response to this information would then be kept in the DOM offices for future review if needed. If current DMH methods are deemed appropriate, they are to be left unchanged and/or incorporated into other LTC Programs for better and more consistent tracking and use of information.

CMS guideline 8:

In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.

Throughout Medicaid LTC programs one entity may serve the client with both the case management function as well as direct services. There are firewalls in place within each program to address Freedom of Choice of Providers. Attached policies 2, 3, 8, and 9 are geared toward ensuring client Freedom of Choice of providers.

Recommendation: The CFCM Learning Collaborative Group recommends the implementation of previous recommendations for CMS guidelines 3, 4 and 7, which come together to address this issue, thus assuring that the responsibilities for this guideline are met. The DOM would verify the presence of documentation of Freedom of Choice within their compliance reviews for each provider. The implementation of these recommendations together will establish and/or strengthen firewalls to decrease the risk for conflict and address it if it arises.

CMS guideline 9:

Meaningful Stakeholder Engagement Strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, managed care organization leadership and case management staff.

The formulation and use of this Learning Collaborative Group has helped to meet the responsibilities of this guideline. For the future, consumer and family involvement can be ensured and incorporated into future activities by the implementation of the recommendation listed below. Information regarding this guideline for DMH programs can also be collected via the Personal Outcome Measures TM and National Core Indicators.

Recommendation: The CFCM Group recommends the implementation of previous recommendations for CMS guidelines 3, 5, and 7 and the final group recommendation (listed below) to comprehensively meet the requirements of this guideline. Also, the Group recommends that the DOM consider future involvement of Stakeholder Groups on a long term basis. These groups should include individuals receiving services.

Note: The policy examples used in the attachment to this statement are taken from the Elderly and Disabled (E&D) Medicaid Waiver Policy Manual.

Recommendation: The CFCM Group recommends that Medicaid policies across the existing Long Term Care (LTC) Programs be updated to exhibit the same standards as listed within these examples.

Exception: The ID/DD Waiver process differs somewhat in certain situations. Namely the fact that we have an extensive grievance process and that we make the initial and redetermination decisions regarding eligibility for the ID/DD Waiver and approved the services on the Plans of Care. Also, the ID/DD Waiver has different performance measures than the other 4 waivers so those cannot be compared across waivers. The attached policy clearly states it is from the E&D Waiver and it generally applies to all waivers, but there are differences that the DMH would need to address if language in the attached policies were to be adopted for all waivers.

Conflict Management/Resolution policies for the Elderly and Disabled Waiver

- 1) Waiver Document, #5- Assurances, D. Choice of Alternatives: The client is given choice of Institutional Placement or Home and Community Based Services and informed of any feasible alternatives under the Waiver (The Informed Choice Document---within the PAS--- provides for this and also gives the individual the opportunity to discuss other waivers or service options)
- 2) Waiver Document, #5- Assurances, E. Free Choice of Provider: A participant may select any willing and qualified provider to furnish Waiver services included in the service plan unless the State has received approval to limit the number of providers..... (The Freedom of Choice Provider list allows the client to review all providers available for the specific service and choose one)
- 3) Waiver Document, #5- Assurances, G.- Fair Hearing- The state provides the opportunity to request a fair hearing to individuals who are a) not given the choice of HCBS b) who are denied the service(s) of their choice or the provider(s) of their choice or c) whose services are denied, reduced, or terminated (This is accomplished through the Notice of Action, which is mailed to the client certified---the only instance in which I am aware that people have been denied the provider of their choice is when we send a referral to the provider and the provider contacts us to say they will not serve the client---this happens for various reasons, they don't have an available staff member in that area, Home Health Agency is not accepting Waiver referrals at that time due to financial or staffing issues, etc.)
- 4) Waiver Document, #5- Assurances, H- Quality Improvement- The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in the application ---this includes item I- public input through stakeholder groups, but also individual home visits with participants in which services, satisfaction, and any conflict can be discussed directly with Medicaid employees
- 5) Performance measures which provide for "double review and oversight" include performance measure #3 which indicates that the Division of Medicaid will actually reassess a sample of Waiver participants to be sure the assessment function has been performed accurately and adequately.
- 6) Waiver document, Appendix B: participant Access and Eligibility: a. procedures,The PAS process requires the participant or their legal representative to sign and attest to their choice of placement on an Informed Choice Form. During this portion of the pre-admission screening process, Long Term Care program options are explained by the Case Manager and the participants indicate their choice of Waiver services or institutional services by evidence of their signature and initials placed by service choice. The Informed Choice section is to match the person's care needs, strengths, and desires with DOM-covered Long Term Care Programs , to ensure the participant's and the participant's family, is able to make an informed choice from the available DOM-covered options----(This allows the client to choose, not only between institutional placement, but also between Waivers which they qualify for---for this reason I am including it in the policies already in place for alleviating conflict---their ability to choose between programs, which also means the ability to choose between case management under E&D, support coordination under other waivers, etc.)
- 7) Waiver Document, Appendix D: Participant-Centered Planning and Service Delivery, b. DOM audits providers annually or more often if deemed necessary and reserves the right to visit participants on this waiver to determine if they are satisfied with their provider and the services they are receiving.

- 8) Waiver document, Performance measure #9 address the DOM ensuring that freedom of choice of providers has been given to Waiver participants. This is also followed with DOM response to complaints or problems—to have the Case Managers submit the freedom of choice documentation and one on one provider training as needed.
 - 9) Waiver document, Appendix F: Participant Rights:- policy attached- this information further explains the methods in place to handle conflict as it arises, including choice of Case Managers and the client receiving their Bill of Rights. This is also followed by Performance Measure # 3 in which the DOM has taken responsibility for identifying those instances in which complaints were addressed and if they were addressed in an appropriate manner and outlines actions if this is not found to be the case
-