



Waiver Review Project Report
LINCOLN, LYON and MURRAY COUNTIES

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Minnesota Department of **Human Services**

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the **ImproveGroup**[™]

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ABOUT THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

The Minnesota Department of Human Services helps people meet their basic needs by providing or administering health care coverage, economic assistance and a variety of services for children, people with disabilities and older Minnesotans. The Minnesota Department of Human Services touches the lives of one in four Minnesotans with a variety of services intended to help people live as independently as possible. DHS is the state's largest agency, with an annual budget of approximately \$8 billion and 6,600 employees located throughout Minnesota.

the ImproveGroup™ ABOUT THE IMPROVE GROUP

The Improve Group is an independent evaluation and planning firm with the mission to help organizations deliver effective services. The research design, data collection, analysis and reporting expertise of the Improve Group particularly emphasizes building the capacity of local organizations to make information meaningful and useful.

Executive Summary

In June 2007, the Minnesota Department of Human Services conducted a review of Lincoln, Lyon and Murray Counties' Home and Community Based Services (HCBS) programs. Lincoln, Lyon and Murray Counties are rural counties located in southeastern Minnesota. The county seat of Lincoln County is located in Ivanhoe, Minnesota and the County has another three cities and 15 townships. The county seat of Lyon County is located in Marshall, Minnesota and the County has another 10 cities and 20 townships. The county seat of Murray County is located in Slayton, Minnesota and the County has another eight cities and 20 townships. In 2005, Lincoln County's population was approximately 6,050, Lyon County's population was approximately 24,472 and Murray County's population was approximately 8,852. Lincoln, Lyon and Murray Counties served a total of 665 people through the HCBS programs in 2005.

Lincoln, Lyon and Murray Human Services operate as one agency that serves participants in HCBS programs across the three counties. Human Services is the lead agency for all HCBS programs, but they receive assistance from Public Health Services of Lincoln, Lyon, Murray and Pipestone Counties. Public health nurses and social workers jointly assess participant needs for participants new to the program in initial assessments. They also work together to conduct joint reassessments for participants have high medical needs. The central intake office for all HCBS programs is located in Murray County; the intake worker electronically forwards all relevant intake information to the appropriate supervisor, who then assigns the participant to a case manager. After cases are assigned, the case manager follows up with a participant to schedule an initial assessment meeting. Agency staff members were very receptive to the Waiver Review process and excited to learn about the findings.

Introduction and Methods

The primary goal of the Waiver Review Project is to support the assurances that the Minnesota Department of Human Services (DHS) makes to the Centers for Medicare and Medicaid Services (CMS) about Home and Community Based Services. The HCBS programs, including five waivers (EW, CAC, CADI, TBI, MRRC) and the Alternative Care program, are overseen by the Minnesota Department of Human Services. When developing the Waiver Review Project, DHS intended to both monitor compliance with state and federal regulations and identify successful practices that improve the quality of service to HCBS participants.

The Waiver Review Process employed seven methods for collecting data to substantiate the State's assurances: (1) participant case files; (2) contracts held by Lincoln, Lyon and Murray Counties for services; (3) policies developed by Lincoln, Lyon and Murray Counties to guide it in administering the HCBS programs; (4) a survey instrument completed by County staff; (5) interviews with administrative and supervisory staff; (6) a focus group of staff working across the six HCBS programs; and (7) County operational indicators developed using state data. Eight-nine (89) case files and fifteen (15) provider contracts were examined during the Lincoln, Lyon and Murray Counties visit. The systematic way the data was collected during this review will be used in other lead agency waiver reviews over the next five years. Much of the data was collected on-site through a three-day site visit process during which participant records and contracts were reviewed and staff participated in interviews and the focus group.

The HCBS quality framework developed by the Centers for Medicare and Medicaid Services¹ was used as a guiding force for this review and includes the following seven framework areas: (1) Participant Access; (2) Person-Centered Planning and Delivery; (3) Provider Capacity and Capabilities; (4) Participant Safeguards; (5) Participant Rights and Responsibilities; (6) Participant Outcomes and Satisfaction; and (7) System Performance.

Waiver Review Findings- County Strengths and Promising Practices

The following findings around Lincoln, Lyon and Murray Counties' promising practices and strengths are drawn from reports by the Counties' staff, reviews of participant case files and provider service contracts and observations made during the site visit.

- Data from multiple sources indicate that the quality of staff is considered strength for Lincoln, Lyon and Murray Counties. Case managers have good relationships with their HCBS participants; they are very participant-focused and responsive to participant needs. Staff members work with participants from multiple programs which ensures they know all of the resources and dynamics in their community. Staff is particularly skilled at identifying good providers to ensure participants get services they need and want. Case managers spend a lot of time out in the

¹ http://www.cms.hhs.gov/HCBS/04_CMSCcommunications.asp#TopOfPage

- communities seeing participants; case managers see 64% of participants twice each year or more.
- Lincoln, Lyon and Murray Counties have established good systems to support case workers in all counties, including unit meetings where issues are discussed and creative solutions are found. Supervisors attend bi-weekly “focus” meetings in which agency-wide priorities are established and discussed. For example, the Counties have recently recognized a delay in the intake process and have established a new system using the SSIS technology which will likely lead to increased speed and efficiencies in the assessment process.
 - There is strong local provider capacity, which allows Lincoln, Lyon and Murray to ensure services for people who need specialty services. The Counties have recognized areas where additional provider capacity is needed and have found ways to meet those needs; for example, dental services are assured through periodic trips to neighboring communities, and the local psychiatric support is supplemented with therapists who travel to the region.
 - Lincoln, Lyon and Murray Counties have achieved high rates of participants in the MRRC program with earned income, particularly those with incomes less than \$250 per month. Sixty-seven percent of MRRC participants earn income. Vocational opportunities could be used in the other disabilities programs, particularly for CADI participants, by using the same network of employers and providers.
 - Lincoln, Lyon and Murray Counties make aggressive use of in-home services to help keep people in community settings. Compared to a cohort of similarly sized counties, the Counties’ EW and CADI participants use more in-home services, including homemakers, home delivered meals, PCA and homecare. Additionally, the CCT provider network serves a higher percentage of participants with high needs than in similarly-sized counties. The Counties have developed a homemaker form to monitor the quality of these services and make sure they continue to help participants stay in their homes.
 - The MRRC program does a good job of person-centered case management and care planning. While screenings for participants in the MRRC program are required to be updated every six years, Lincoln, Lyon and Murray case managers routinely exceed

this requirement; screenings are completed every year or more frequently in times of significant change for a participant, helping case managers monitor participant needs and do effective care planning. All screenings in the Counties had the required signatures, identified participant needs, and described the services to be provided. In addition, the MRRC care plan format is a very strong and includes excellent goal statements that are written in the first person, making the result very person-centered.

- Lincoln, Lyon and Murray Counties use the State's model contract template for new contracts being executed. The template ensures that contracts incorporate performance measures and monitoring procedures for provider quality, that care plan goals are achieved and that participant outcomes are established. The template has not yet been used in all programs; the contract model will be modified to include the AC program and EW waivers. Some strengths in contracts include documented process for monitoring whether individual care plan goals are achieved and the consequences for non-performance.
- Lincoln, Lyon and Murray Counties have begun developing ways of improving and monitoring provider quality. For example, staff advocated for change at the local DAC when problems in quality were noted, and the center subsequently made leadership changes. Similarly, staff developed a homemaker feedback form to select services, monitor whether the services were actually provided and note provider quality.

Waiver Review Findings- County Barriers and Areas for Improvement

The following findings around Lincoln, Lyon and Murray Counties' barriers and areas for improvement are drawn from reports by the Counties' staff, reviews of participant case files and provider service contracts and observations made during the site visit.

- The completeness of case files varied greatly from participant to participant. Several required forms, including OBRA Level One forms, ICF/MR level of care forms, TBI Waiver Assessment and Determination forms and the CAC Application/Reassessment Support Plan were missing from the case file.

- The care plan formats used in Lincoln, Lyon and Murray Counties did not include several required elements. Health and safety issues were missing or with less documentation than expected in 19% percent of cases. Participant needs were missing or had less documentation than expected in 40% of cases. In the nineteen cases with an identified, unpaid caregiver, just 53% of care plans addressed caregiver needs. For CCT programs, emergency contact and back up plan information is required and just 15% of care plans included this information.
- While the contract format that Lincoln, Lyon and Murray have adopted is good, current contracts do not include all of the required elements and the format is not being used in all programs. One provider contract was not current; it did not include signatures required for execution. Additionally, many contracts were missing a list of HCBS services to be provided (missing in 55% of reviewed contracts) and required assisted living elements such as a monthly rate based on care plans was missing in both reviewed assisted living contracts. Rent or food was included in the monthly rate in one of two contracts (the monthly rate should exclude rent or food costs).

Recommendations and Corrective Action Requirements

The following are recommendations and required corrective actions developed by the Waiver Review Team. The recommendations are intended to be ideas and suggestions that could help Lincoln, Lyon and Murray Counties work toward reaching their goals around HCBS program administration. Corrective action requirements are areas where Lincoln, Lyon and Murray Counties were found to be inconsistent in meeting state and federal requirements and will require a response by Lincoln, Lyon and Murray Counties.

Recommendations

The following recommendations would benefit Lincoln, Lyon and Murray Counties and its HCBS participants.

- While Lincoln, Lyon and Murray Counties are using the model contract, it is not being used for all programs. In addition, the contracting process could be strengthened by using the attachments to note all services the contract is for and noting which reports are being

required from providers; the reporting form for homemaker services works well and could be adapted for other services and incorporated into the contract. Having a designated person to manage the contracts for HCBS programs would also strengthen the process. The process for modifying rates could be clarified to reduce the burden on case managers. County-negotiated rates should be included as attachments in the contract, as should rate-setting tools for case manager-negotiated rates. The Counties should maintain signed copies of all host county contracts to ensure that contracts are current for all services being provided. Contracts should be revisited every three to four years to ensure that they are accomplishing the quality and type of services expected for participants.

- Continue to develop relationships with schools to ensure that they know of the services available for youth. This will encourage early identification and referral for youth who may be eligible for HCBS services, particularly MRRC. This could include formal presentations to school staff about the Counties' services and their potential role in transition planning. Develop a packet which schools can provide to parents which would explain the Counties' role in the planning process and benefits of early involvement.
- Higher proportions of CCT participants are being served in the community than in the elderly or MRRC programs. Consider working with providers to develop available service networks for serving EW/AC and MRRC participants in their homes, such as care giver supports, home modifications and use of PCA services. In addition, consider education or explanation that may be needed to make these options attractive to participants; a few case file reviews indicated that participants had refused specific recommended services or to receive an assessment or care plan.
- Approximately 8% of allowed funds were unused in the MRRC program and 16% of allowed funds were unused in the CCT programs during calendar year 2005. This represents people who are not receiving services, particularly those on the waiting lists. Because Lincoln, Lyon and Murray Counties are already a joint human service agency and share the financial risks of serving participants, and caseloads are relatively stable, these reserves can be reduced to closer to 3% in the MRRC program and 5% for CCT programs.
- Make use of some of the flexible service options for those who are on the waiver programs and those who are waiting for services. For example, consumer directed community supports can be used for participants who are in outlying areas or who have been unable

to find local culturally-appropriate services, and consumer support grants or PCA can be used for families with children who need assistance but have not been added to the waiver programs.

- Considerable variation in the thoroughness of case file documentation was noted. Developing a more formal process for auditing documentation in case files, such as a checklist or review system, can ensure that all case managers understand expectations for documentation and are held accountable for maintaining their case files. This is particularly important when face-to-face contact with some case managers is limited because they telecommute or are located in different offices.
- Identify and implement one care plan format to be used in the Counties that includes all required documentation for all HCBS participants to ensure that missing elements such as emergency contract information, health and safety issues and participant and caregiver needs are included. The format can also include any requirements of the MSHO health plans. There may be more challenges to implementing one care plan across MSHO providers; however, other counties have found that MSHO health plans are willing to cooperate in this process.
- Expand the currently strong efforts at monitoring and improving provider quality, particularly that of the homemaker feedback form that helps participants to select services, monitor whether the services were actually provided and note provider quality.

Corrective Action Requirements

The following are areas in which Lincoln, Lyon and Murray Counties will be required to take corrective action. Correction actions are cited when it is determined that a pattern of noncompliance is discovered. There may be individual cases that need follow-up when the noncompliance is more incidental in nature.

- Beginning immediately, ensure that 80% of LTC Screenings for CCT programs occur within 10 days of referral and that 80% of DD screenings for the MRRC program occur within 90 days of referral. State legislation requires that LTC screenings should be conducted within 14 days (10 business days) and that DD screenings should be conducted within 90 days of a request for screening, which is defined as the date the assessment is requested. Currently, 77% of LTC screenings for the elderly programs and 79% of screenings for CAC,

CADI and TBI participants occur within this 10 business day timeframe and 75% of DD screenings for MRRC participants occur within this 90 day timeframe. If a screening cannot take place in the required time period, document the reason for the delay in the participant's case file.

- Beginning immediately, ensure that the completion of care plans for CCT cases occurs within 10 days of the assessment. State legislation requires that care plans be completed within 14 days (10 business days) of the completion of the assessment. Currently, 15 of 34 CCT care plans reviewed were not completed within this timeframe.
- Complete an OBRA Level One form for all LTC participants that do not have one in the next 30 days.² Maintain a copy of this completed form in the participant's case file. Thirty-nine percent of all LTC cases were missing this form. While it is a requirement that this form be completed at time of first assessment and kept in the case file, it is considered a promising practice to update this form yearly.
- Complete a TBI Waiver Assessment and Determination Form for all the participants in this program that do not have this form within the next 30 days. None of the six reviewed cases had this form in the case file.
- Complete a CAC Application/Reassessment Support Plan for all the participants in this program that do not have this form within the next 30 days. Of the eight cases that were reviewed, one had a form that was not completed and two were missing the form.
- Ensure that care plans include all required documentation for HCBS participants, in all programs including identifying participant needs and health and safety issues. Ensure that the care plan is signed and dated by the participant or an authorized representative. All care plans must be updated within 6 months.
- Include a back up plan and emergency contact information in the care plan of all CAC, CADI and TBI (CCT) participants. All care plans must be updated with this information within six months. This is required for all CCT programs to ensure health and safety needs

² The OBRA Level One form can be accessed at:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=id_000688

are being met in the community. In Lincoln, Lyon and Murray Counties 85% of the 34 CCT cases reviewed did not include a back up plan or emergency contact information.

- Beginning immediately, case managers must conduct face-to-face visits with participants as required in the federally approved waiver plan. While biannual visits are required for all CCT participants, 20% of CADI cases (four cases) and one CAC case had only annual visits.

Appendix: Glossary of Terms

AC is the Alternative Care program

CDCS refers to Consumer-Directed Community Services

CAC is the Community Alternative Care Waiver

CADI is Community Alternatives for Disabled Individuals Waiver

Care Plan is the service plan developed by the HCBS participant's case manager (also referred to as Community Support Plan, Individual Support Plan and Individual Service Plan)

CCT refers to the CAC, CADI and TBI programs, which serve people with disabilities

CMS is the federal Centers for Medicare and Medicaid Services

Disability waiver programs refers to the CAC, CADI and TBI Waiver programs

EW is the Elderly Waiver

DHS is the Minnesota Department of Human Services

HCBS are home and community-based services for persons with disabilities and the elderly: For the purpose of this report, HCBS include the Alternative Care program, CAC, CADI, Elderly, MRRC and TBI Waivers

Home care services refers to extended home care services, including personal care attendant services

MRRC is Mental Retardation and Related Conditions and refers to the program serving persons with developmental disabilities

Local Lead Agency (LLA) is the local organization that administers the HCBS programs: LLA may be a county department, health plan or tribal community

Participant *case files* were examined for much of the evidence cited in this report. They included the written participant records and information of case management activity from electronic tracking systems

Operational process- refers the actual methods and activities used by a LLA to accomplish business objectives

Promising practice: An operational process used by the LLA that consistently produces a desired result beyond minimum expectations

Participants are individuals enrolled and receiving services in a HCBS program

Policies are written procedures used by LLA's to guide their operations

Provider contracts are agreements for goods and services for HCBS participants, executed by the LLA with local vendors

Site visits were conducted to collect most of the data used in this report

TBI is the Traumatic Brain Injury Waiver