Minnesota Department of Human Services Waiver Review Initiative

Round II Report (July 2012 to May 2015)

Summary report for all lead agencies

Contents

Executive Summary

The primary goal of the Lead Agency Waiver Review Initiative is to determine how Minnesota's Home and Community-Based Service (HCBS) programs are operating and meeting the needs of the people they serve. This includes assuring compliance by lead agencies in the administration of HCBS programs and performance management, identifying promising practices, tracking local improvements, and obtaining feedback about DHS. The Lead Agency Waiver Review supports the missions of the newly formed DHS administrations of Continuing Care for Older Adults (CCOA) and Community Supports (CSA), which includes helping to ensure that long term care services and supports continue to improve the quality of life of Minnesotans and are sustainable over time. From July 2012 to May 2015, DHS completed reviews of 83 lead agencies (87 counties and two tribes) which included the review of over 6,400 case files and discussions with over 1,000 lead agency staff.

Findings from Round II

Case Management

Case managers play a significant role in providing quality services and advocacy for waiver participants.

- Case managers work across lead agency departments and disciplines to serve participants. By working together with other units, case managers are better able to navigate the system on behalf of waiver participants and ensure participant needs are being met.
- Case managers have regular contact with participants and their families, which allows them to maintain strong relationships and monitor the participant's health and safety needs. On average, case managers visited participants 3.9 times in the 18 months prior to the lead agency's waiver review site visit.

Assessment and Care Planning

A majority of the care plans reviewed contained detailed information addressing the required elements.

- Lead agencies have seen improvements in results for completing assessments within required timelines since the first round of reviews. Seventy-six percent (76%) of assessments/screenings across programs were completed within the required timelines.
- A majority (82%) of care plans were written using participant-friendly language which could include using the participant's name and avoiding use of acronyms or medical jargon. In addition, 68% of care plans included individualized and meaningful goals.

Case File Technical Compliance

Three lead agencies case files were found to be 100% compliant with all requirements. Lead agencies have 60 days after their review to submit evidence that they had brought all cases reviewed into full compliance.

- The areas where lead agency case files were most frequently found to be compliant include: current DD screening documents (98%), OBRA Level One documentation (98%), and participants' acknowledgement of choice in services (96%).
- Certain areas of case file compliance posed challenges for lead agencies; only 71% of case files contained documentation of current right to appeal information and 79% had complete emergency back-up plans.

Internal and External Relationships

Case managers are connected to their communities and aware of resources available. Case managers develop close working relationships with providers, which allow them to collaborate to meet the needs of participants.

- Most lead agencies (71%) indicated in the Quality Assurance Plan (QA) survey that they always have case managers document provider performance, and that case managers always provide oversight to providers on a systematic basis (69%).

- 82% of providers surveyed indicated they submit monitoring reports to the lead agency, and 87% indicated that they received the needed assistance when it was requested from the lead agency most or all of the time.

Provider Service Capacity and Development

Although waiver programs present the opportunity and flexibility for lead agencies and providers to develop new and creative services, progress in emerging areas has been slow.

- Lead agencies are partnering with providers to develop creative housing solutions for participants including incorporating assistive technology so that participants can have more independent living situations. However, the percentage of waiver participants served at home remained level from 2011 to 2013 for AC/EW (75% in 2011 and 2013) and DD participants (35% in 2011 and 2013), but fell slightly for CCB (63% in 2011 and 62% in 2013).
- Lead agencies are working to create more meaningful employment opportunities for participants by building relationships with local businesses. However, the percentage of working age adults employed and earning at least $250 per month improved only marginally between 2011 and 2013 for CCB (from 10% to 11%) and DD participants (from 22% to 23%).

Non-Enrolled Vendor Monitoring

In order to improve access and vendor choice for waiver participants, many lead agencies act as the pass through billing agent for non-MHCP enrolled vendors.

- Since this change to DHS and lead agency operations is new, the review of the non-enrolled vendor monitoring process is meant to be educational and advisory. DHS is not issuing corrective actions for the requirement at this time. However, if any non-compliance is identified, the lead agency is required to remediate any required documentation.
- DHS continues to issue guidance and sample templates via the CBSM to assist lead agencies in documenting that non-enrolled vendors meet all applicable service standards.

Waiver Allocation and Management

Some lead agencies had room in their budgets to enhance services or add more participants to programs.

- In the first year, 11 of 24 lead agencies (46%) were given the recommendation to reduce their budget reserve because they had a more than adequate allocation left to manage risks associated with new high cost participants while also providing services to current participants. However, by the third year, only nine out of 30 lead agencies (30%) were issued this recommendation.
- Over the course of Round II, several lead agencies have developed alliances with other nearby counties to pool and manage their allocations. This allows them to serve more participants with the waiver programs while better managing risk.

Follow-Up Survey Results

Approximately one year after conducting the on-site waiver review, DHS sends a brief survey to each lead agency to learn more about changes happening at the lead agency, monitor ongoing compliance, and continue to build relationships with lead agency staff.

- Of the 83 lead agencies visited, 55 have submitted a follow up survey as of May 2015. The remaining 28 will receive and submit their survey over the course of the next year.
- Of 194 corrective actions issued to these lead agencies, 94% have resulted in a compliant practice. Lead agencies that acknowledged ongoing struggles are asked to update their corrective action plans.

Continuous Improvement Efforts Within DHS

While on-site during the reviews, observations are made regarding items that create stumbling blocks to lead agency compliance. These learnings are passed onto the proper areas within DHS to see where improvements can be made.

- Forms are updated to include additional program requirements and allow for easier compliance. Based on findings from waiver reviews, updates have been made to several forms, including DHS and MCO care plans templates.

- Feedback is shared with policy staff to identify areas where additional clarifications about HCBS requirements are needed. This has included updates to eDocs forms and the CBSM.
- Additional support was provided to three lead agencies identified as needing additional monitoring to ensure compliance with HCBS program requirements. Follow up site visits were made to these lead agencies about one year after their initial review. Another sample of case files was reviewed and evaluated to see what changes were made to their business practices. Thanks to the commitment of the staff, compliance at these lead agencies significantly improved in just one year.

Conclusion

The Lead Agency Waiver Review Initiative has been successful in using multiple data collection methods to assess the administration of the waiver programs throughout lead agencies in Minnesota. In particular, the reviews serve as an effective mechanism to support lead agencies in their work, promote collaboration across lead agencies, and encourage the use of best practices to advance managing by performance. As DHS prepares for the Round III of the Lead Agency Waiver Review site visits, the review process will continue to evolve along with the HCBS programs. Increased focus will be placed on emerging policies and programs including person-centered planning and use of positive support transition plans. The review process is developing a robust preformance measurement improvement strategy that includes setting benchmarks. DHS hopes to continue to see strong technical compliance from lead agencies as well as innovative ideas for how to better meet local needs and serve waiver participants.

Acknowledgements

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About the Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) 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. DHS's CCA strives to improve the dignity, health and independence of Minnesotans in its annual administration and supervision of $3.9 billion in state and federal funds, which serve over 360,000 individuals.

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 emphasizes building the capacity of local organizations to make information meaningful and useful.

About MinnesotaHCBS.info

The Waiver Review Initiative website (http://www.minnesotaHCBS.info/) was created to be a communication tool and resource center where local agencies can access tools, resources, and promising practices in the administration of HCBS.

Introduction

History and Background

Since 2006, DHS has conducted a thorough review of Minnesota's Home and Community-Based Service (HCBS) programs. These HCBS programs help Minnesotans stay in their homes and receive services and supports as they age and regardless of ability.

The Lead Agency Waiver Review Initiative examines the six HCBS programs of: (1) Developmental Disabilities (DD) Waiver, (2) Community Alternative Care (CAC) Waiver, (3) Community Alternatives for Disabled Individuals (CADI) Waiver, (4) Brain Injury (BI) Waiver, (5) Elderly Waiver (EW) and (6) Alternative Care (AC) Program. These are generally grouped by the population they serve: the DD waiver program serves people with developmental disabilities; the CAC, CADI and BI programs serve people with disabilities and are referred to as the CCB programs; and the EW and AC programs serve persons aged 65 and older.

Goals and Purpose of Waiver Review Initiative

The primary goal of the Lead Agency Waiver Review Initiative is to assure compliance by lead agencies (counties, tribes, and Managed Care Organizations) in the administration of Minnesota's Home and Community-Based Service (HCBS) programs. The reviews allow DHS to document compliance, and remediation when necessary, to the Center for Medicare and Medicaid Services (CMS). CMS requires states to provide valid evidence that the assurances made in its federally approved waiver plans are being met. In addition to monitoring compliance with state and federal requirements, DHS developed this review to identify promising practices that improve the quality of service to HCBS participants, track local improvements, and obtain feedback on training and technical assistance provided by the Continuing Care for Older Adults Administration (CCOA) and Community Supports Administration (CSA) at DHS.

The Lead Agency Waiver Review Initiative supports the CCOA's and CSA's vision to ensure that the long term services and supports, including nursing facilities, HCBS waivers, and state plan services, like the Personal Care Assistance (PCA) program, continue to meet the needs of Minnesotans and are sustainable over time. Nearly $3.9 billion in state and federal funds is spent

each year on long-term care in Minnesota and costs are growing by nearly 6% each year. As the gap between the demand for services and the revenues available continues to expand, the CCOA and CSA would like to ensure that Minnesotans are able to access high-quality long-term services and supports. Success hinges on partnerships with lead agencies, tribes, and other agencies involved in administering and delivering these programs.

Review Process and Sources of Data

The structure and process for the second round of waiver reviews is similar to the first round. DHS uses a comprehensive, mixed-method approach that uses multiple sources of information to evaluate the administration of HCBS programs in each lead agency. Table 1 below briefly describes the purpose of each data source examined during the waiver review. These methods are intended to provide a full picture of compliance, context, and practices within each lead agency and further explain how participants benefit from the HCBS programs.

Table 1. Sources of data for HCBS Waiver Review

Data source	Purpose
Lead Agency Program Summary data (MMIS/MAXIS)	Compares lead agency to State averages and cohort averages for several operational indicators. The cohort groups are based on similarly sized HCBS programs.
Participant case files	Identifies compliance with program requirements and assesses quality of assessment, care plans, and case management.
Provider survey	The survey asks providers to give feedback about their relationship and communication with the lead agency as well as identify strengths and challenges facing the lead agency.
Quality Assurance Plan (QA) survey	A self-assessment of a lead agencies compliance state and federal requirements, quality assurance activities, and policies/practices related to health and safety. Lead agency compliance with requirements ranges from 85% to 100%.
Case manager focus group	Discusses trends, barriers and opportunities within community and explores practices that could be adapted by other LAs.
Supervisor interview(s)	Discusses agency policies and procedures for HCBS Waiver program administration.
Supervisor meeting	Discuss lead agency's results from the QA and provider surveys
Non-enrolled vendor meeting	Discuss leady agency's practices for verifying that non-enrolled Tier 2 and 3 service vendors are qualified to deliver services

Data collected prior to the site visit includes the Quality Assurance Plan (QA) survey, the provider survey, interviews with lead agency staff, and program summary data. However, most of the data collected for the HCBS review is done during a multi-day site visit. This site visit includes a review of participant case files, focus groups with lead agency staff, and meetings at which preliminary findings are discussed for greater understanding of context. The data collection methods are intended to glean supporting information and to focus on quality indicators that were developed to evaluate different aspects of the case management provided to waiver participants. Results are used to identify lead agency strengths and to support recommendations and corrective actions that are issued. By using this process, DHS is able to better articulate the strengths of the lead agencies and where improvements should be made.

The data collected is analyzed and reported back to each lead agency. DHS encourages each lead agency to provide feedback and comments on their report and views the process as an opportunity to highlight promising practices and to collaborate to address any challenges.

Round II Overview

Site visits for the second round of waiver reviews occurred more quickly than the first round, which took six years to complete. The site visits for Round II began in July 2012 and were completed by the spring of 2015. This included 83 reviews of all 87 counties[1] and two Tribes[2] during the second round of the HCBS Waiver Review. A summary map of the lead agencies reviewed during Round II can be found in Appendix A. Over the past three years, a large amount of data has been collected through the review of these lead agencies, including the review of nearly 6,500 case files and talking to over 1,000 lead agency staff. Table 2 summarizes the data collected in Round II and Table 3 shows the number of cases reviewed in each program.

[1] Faribault and Martin Counties; Lincoln, Lyon, Murray, Pipestone, Redwood and Rock counties make up the Southwest Minnesota Health & Human Services Department.
[2] Leech Lake Band of Ojibwe and White Earth Nation

Table 2. Summary of data collected in Round II.

Method	Year 1	Year 2	Year 3	Round II Total
Case Files Reviewed	1,988	2,138	2,320	6,446
Providers Surveyed	472	399	536	1,407
Supervisors Interviewed	92	66	65	223
Focus Groups	31	34	35	100
Focus Group participants	278	301	315	894
Quality Assurance Surveys	24	29	30	83
Non-Enrolled Vendor Claims Reviewed	NA	NA	104	104

Table 3. Number of cases reviewed by program in Round II.

Program	Year 1	Year 2	Year 3	Round II Total
Developmental Disabilities (DD) Waiver	439	491	508	1,438
Community Alternative Care (CAC) Waiver	102	92	113	307
Community Alternatives for Disabled Individuals (CADI) Waiver	455	497	540	1,492
Brain Injury (BI) Waiver	137	150	211	498
Elderly Waiver (EW)	595	602	599	1,796
Alternative Care (AC) Program	260	306	350	916

Findings from Round II

Case Management

Case managers play a significant role in the ability of the HCBS programs to realize the goal of safely serving participants in their own homes and communities. Case managers have the responsibility of assessing participant needs, care planning, coordinating services, and ongoing monitoring of the participant's health and safety through regular contact and visits. The Lead Agency Waiver Review Initiative gathers information about case management from several sources, including a review of case files and notes, a provider survey, and a focus group with lead agency case managers. Through these sources, several overarching themes were identified this past year:

Case management was consistently a strength for lead agencies in Round II. Case managers throughout the state provide quality services and advocacy for waiver participants by being responsive to participants and providers, building relationships with families, and collaborating with one another.

- In 88% (5,656 out of 6,446) of cases reviewed, case managers were rated as being responsive to participant needs.[3] In addition, 87% of providers also said that case managers are responsive to participant changing needs most or all of the time.[4]

- 51% (713 out of 1,411) of providers indicated that a top strength of the lead agency they work with is the good, open communication between case managers, participant, and providers. In addition, 39% of providers indicated a top strength of the lead agency they work with is that case managers are well-trained and knowledgeable.[5]

Case managers are required to conduct a face-to-face visit with participants a minimum number of times depending on the waiver program. For EW and AC programs, participants must receive a face-to-face visit at least once every 12 months. CAC, CADI, and BI participants must receive at least two face-to-face visits in the past 12 months. DD participants must receive a face-to-face

[3] Data from case file review quality questions.
[4] Data from provider survey.
[5] Data from provider survey.

visit every six months. In most cases, **case managers are consistently meeting requirements for visiting participants**. Frequent contact with participants and their families allows case managers to maintain strong relationships and monitor changes in the participant's health and safety needs. The review of case files and case notes revealed that case managers communicate with participants through several means including face-to-face visits, phone calls, and e-mail. In addition, case managers often have contact with participants out in the community, in their home environment, and at places of employment. In 84% (5,388 out of 6,446 cases) of cases reviewed, case managers were rated as having visits or interactions with participants that respond to the participants' preferences.[6] Table 5 below shows the average number of visits conducted by case managers by program in the 18 months prior to their lead agency's review.

Table 4. Average number of visits in past 18 months by program.

	Year 1	Year 2	Year 3	Round II
CAC	3.3	3.9	3.0	3.4
CADI	3.7	4.4	4.0	4.1
BI	3.9	4.9	4.7	4.5
DD	4.1	5.3	4.1	4.5
EW	3.3	4.0	3.2	3.5
AC	2.9	3.1	2.9	3.0

In Round II, case managers visited participants 3.9 times in the 18 months prior to the lead agency's waiver review visit across all cohorts. Cohort 1 lead agencies visited waiver participants the most frequently across the three years and had a total average of 4.8 visits in the past 18 months. A breakdown of the average number of visits by cohort in the previous 18 months is displayed below in Table 4.

[6] Data from case file review quality questions.

Table 5. Average number of visits by case managers in the 18 month prior to the waiver review by cohort.

Cohort	Year 1	Year 2	Year 3	Round II
Cohort 1	4.5	5.7	3.9	4.8
Cohort 2	4.5	4.8	3.7	4.4
Cohort 3	3.3	3.9	3.9	3.7
Cohort 4	4.2	4.1	3.0	4.0
Cohort 5	2.9	3.1	3.5	3.2
All Cohorts	**3.6**	**4.3**	**3.7**	**3.9**

Common Recommendations for Case Management

DHS issues recommendations to lead agencies based on data gathered through the review process. One common recommendation is to **develop systems or practices to support case managers**. About half of lead agencies visited during Round II received this recommendation to improve case management quality and efficiency based on the agency's unique circumstances. The waiver team encountered lead agencies experiencing periods of significant staff turnover, which adds additional stress on both case managers and supervisors to manage additional cases, fill other roles outside of case management, and to provide training and guidance to new hires. As caseloads increase and participant needs become more complex, existing case managers in several lead agencies have found it increasingly difficult to provide quality case management including visiting participants regularly and keeping up with all the new policy and program changes. DHS has suggested designating a lead worker or have case managers specialize in a program area to establish consistency and make it easier to stay current with program and policy changes.

Contracted case management services are often recommended to help lead agencies manage growing program caseloads, serve participants that live outside of the region, and to provide culturally appropriate services. This recommendation was given to 37 of 83 lead agencies (45%). Contracted case management can improve oversight and result in a more effective use of lead agency case management time. For participants placed in other counties, a contracted case manager often has more knowledge of local resources to ensure quality service delivery. This also reduces some burden for case managers as some cases require significant travel time. Contracted case management can also be used to reach more diverse populations as certain contracted agencies have established staff who possess language skills and familiarity with those cultural communities. Lead agencies who have found success using contracted case management have developed systems and procedures for providing support and maintaining expectations of contracted case managers to ensure quality case management.

Best Practice: Customizing Case Management

In response to changing populations and needs across Minnesota communities, several lead agencies have assigned case managers who best fit participants based on their medical, mental health, or cultural needs. For example, Kanabec County Family Services typically assigns participants with high medical needs to a case manager from the Public Health department. The relationship between the two departments helps bring an outside perspective, which is valuable in meeting participants' unique needs. In addition, Ramsey County typically assigns cases to assessors and case managers partially based on the participant's preferred language and culture to help meet the needs of their culturally diverse population.

Assessment and Care Planning

The assessment or screening and care plan contain information about the participant's health, social, and psychological needs and preferences, and serves as a tool to determine the types of supports and services required to maintain a participant in the least restrictive environment possible. The annual care plan (Individual Service Plan (ISP) or Community Support Plan (CSP)) is the one document that all participants receive, and it is required to include detailed information about the participant's outcomes and goals, health and safety issues, needs, and the services planned to address those needs. The LTCC Assessment, DD Screening, MnCHOICES

Assessment, and care plans are all reviewed for required elements and quality using a comprehensive list of criteria during the on-site visit.

Lead agencies started implementing MnCHOICES in the Fall of 2013 and began utilizing the MnCHOICES assessment tool in place of the traditional LTCC and DD Screening for new waiver participants. MnCHOICES assessments were incorporated into the review process in July 2014. DHS also launched the Community Support Plan with Coordinated Services and Supports (DHS-6791B) in conjunction with MnCHOICES and has recommended that lead agencies use that care plan format across all waiver programs. Lead agencies expressed challenges preparing for the implementation of MnCHOICES. Staff frequently shared that the process of acclimating to the new assessment tool and technology has been challenging. In addition, staff questioned the person-centeredness of the tool, often expressing frustration with the amount of time necessary to complete assessments.

Since year one of the Waiver Review, lead agencies have improved in the area of timeliness of referral to assessment. 13 out of 24 lead agencies (54%) in year one received a corrective action in this area, which improved to nine out of 29 lead agencies (31%) in year two and only eight out of 30 lead agencies (27%) in year three. In preparation for MnCHOICES, many lead agencies have restructured their intake and assessment processes to more efficiently meet timelines, which may be a contributing factor to this improvement.

A majority of the care plans reviewed contained detailed information addressing the required elements. The DD waiver program has produced the strongest results; DD care plans included detailed information about the participant 89% of the time compared to 63% in all other LTC cases. In many cases, DD care plans provided a rich narrative that linked individual needs and desires with specific goals and supporting services. While the care plans used by lead agencies in the long term care program were typically not found to be as person-centered and detailed, they still contained a majority of required elements. Lead agencies improved each year at including services, goals and outcomes, health and safety issues, and participant needs in care plans. Table 6 below shows the percentage of care plans that met or exceeded average documentation standards all programs. For results by program, see the Waiver Review Performance Indicator Dashboard in Appendix B.

Table 6. Percent of care plans meeting or exceeding average standards across all programs.[7]

	Year 1	Year 2	Year 3	Round II
Services Included	97%	99%	99%	99%
Participant Goals and Outcomes Included	97%	99%	99%	99%
Health and Safety Issues Included	95%	99%	99%	98%
Participant Needs Included	95%	99%	99%	98%

In addition to the content of care plans, the review looks at whether screenings or assessments and care plans are current. Overall, **timeliness for the care planning process is going well** across the state.

- 99% of care plans were current at the time of review, and were signed by the participant and/or legal rep, guardian.[8]
- 99% of LTCC assessments were current at the time of the review.[9]
- 95% of cases had a participant care plan completed within the required 50 day timeframe from the assessment.[10]
- In total, 63 MnCHOICES cases were reviewed in Round II. 81% had a care plan completed within the required 50 day timeframe from the assessment.[11]
- 98% of MnCHOICES cases had a current care plan at the time of the review.
- 98% of DD screenings were current at the time of the review, and 92% included all relevant signatures.[12]

In addition to reviewing case files for technical compliance with State and Federal requirements, more attention is being given to quality during the review. Quality indicators were developed to

[7] A case file is compliant in the above documentation areas (services included, participant goals and outcomes, health and safety issues and participant needs) if the plan is judged to be meeting, exceeding, or being below average documentation standards. A case file is non-compliant if there is no information included in the care plan about services included, participant goals and outcomes, health and safety issues or participant needs.
[8] Data from case file review.
[9] Data from case file review.
[10] Data from case file review.
[11] Data from case file review.
[12] Data from case file review.

evaluate different aspects of the case management provided to waiver participants. Results are used to identify lead agency strengths and complement findings from data gathered from other sources during the review. Overall in Round II, a majority (89%) of the assessments and screenings reviewed were fully completed and 69% of the care plans reviewed were rated as being comprehensive and well-completed. Figure 3 below shows additional quality measure results from the case file review.

Table 7. Assessment and care plan quality measures.

	Year 1	Year 2	Year 3	Round II
Notes to explain IADLs and ADLs were included in assessment or screening	46%	58%	65%	57%
Participant friendly language was used in the care plan	81%	85%	80%	82%
Participant goals in the care plan were individualized and meaningful	61%	72%	71%	68%

Common Recommendations for Assessment and Care Planning

In accordance to Minnesota's Olmstead Plan, DHS is increasing its effort to ensure that lead agencies provide person-centered planning to waiver participants. DHS partners with the University of Minnesota to offer trainings on person-centered thinking and approaches to service planning for providers, lead agency staff, and other stakeholders. Recommendations around person-centered service delivery were given to lead agencies during Round II. In the area of care planning, a common recommendation was to **update care plan formats to ensure that the completed care plan is a person-centered and participant-friendly document in addition to including required information.** This recommendation was given to five of 24 lead agencies (21%) in year one, 12 of 29 lead agencies (41%) in year two, and eight of 30 lead agencies (27%) in year 3.

A quality care plan should be person-centered and participant-friendly. This means including details such as the participant's name instead of "client," "member," or "consumer." The goals in the care plan should be meaningful and unique to the participant and incorporate their preferences. Completion by the case manager and the template format both impact the quality of the care plan. Several examples that address required elements and can result in a high quality care plan for the participant are available here: http://www.minnesotahcbs.info/content/care-plans.

Best Practice: Assessment and Care Planning

Marshall County case managers demonstrate person-centered thinking in their care plans. In addition to using participant-friendly language and including individualized and meaningful goals, staff work with participants and their families to develop "eco-maps" that include primary contact information for all the important individuals and organizations in the participant's network, including family members, friends, and service providers. This practice provides a snapshot of each participant's unique web of supports and is a strong example of person-centered documentation.

Case File Technical Compliance

The Lead Agency Waiver Review collects data from participant case files to monitor compliance with state and federal requirements. The comprehensive process includes a review of a sample of the lead agency's current waiver cases. The cases reviewed are selected by drawing a 10% random sample of cases from each program with a minimum of 10 cases reviewed in each program. If the lead agency has less than 10 cases in any one program, all of the existing cases in that program are reviewed. The sampling methodology used is statistically valid and meets CMS criteria. Reviewers look for current documentation with relevant signatures and dates for items required for the HCBS programs. The data is collected, validated, and analyzed on-site. The results of the case file review are used to inform corrective actions issued to the lead agency, and to document program strengths.

In year one of Round II, 95 corrective actions were issued. In year two, that number fell to 89 and in year three, it rose slightly to 90. Some of the strategies and practices that these lead agencies have used to maintain consistency and compliance include electronic case files, visit sheets, shared drives to store current forms, and support from case aides.

Best Practice: Technical compliance

In all, 13 lead agencies received no corrective actions! A select few not only had no corrective actions, but also met all HCBS program requirements in the case file sample reviewed during their site visit. A special "kudos" to:

- Cottonwood County of the Des Moines Valley Health and Human Services (Cottonwood and Jackson Counties)
- Grant
- Kandiyohi
- Marshall
- Stevens
- Traverse

Case managers are consistently completing most required documentation and including it in participant case files. The OBRA Level I form (98%), ICF/DD Level of Care (94%), consent to release information (92%), and privacy practices (HIPAA) (88%) had high rates of compliance across all lead agencies reviewed in Round II.

Despite the high compliance rate for these forms, completing other required documentation has been problematic for some lead agencies. When this occurs, corrective actions are issued and the lead agency must immediately resolve the issue. The most common corrective action issued in Round II was right to appeal, HIPAA and timeliness of LTCC assessments. In year one and two, the majority of lead agencies received a corrective action for right to appeal, (75% and 55%, respectively). However, in year three there was some improvement since 50% of lead agencies were issued this corrective action. In year three there were also fewer lead agencies that were issued corrective actions around HIPAA and timeliness of LTCC assessments after referral. However, there were more lead agencies who were issued a corrective action around frequency of required visits compared with year two (23% vs. 7%). Table 5 includes more detailed

information about compliance for items with the highest number of corrective actions. The entire list of compliance items can be found in Appendix C.

Table 8. Most common corrective actions issued to lead agencies in Round II

Corrective Action	Year 1	Year 2	Year 3	Round II Total
Person Informed of right to appeal documentation in the case file	75%	55%	50%	59%
Person Informed privacy practice (HIPAA) documentation in the case file	54%	31%	27%	36%
Timeliness of LTCC assessment	54%	31%	27%	36%
Back-up plan	29%	21%	20%	23%
Care plan signed and dated by all relevant parties and Choice questions answered in care plan	13%	31%	13%	19%
Required number of visits for each program	29%	7%	23%	19%
Informed consent documentation in the case file	21%	21%	7%	16%
Employment assessed	-	17%	23%	14%
Related Conditions checklist in case file (DD only)	21%	17%	3%	13%
BI Form	4%	14%	13%	11%
Care plan is current	4%	14%	10%	10%
DD screening document signed by all relevant parties (DD only)	4%	14%	10%	10%

Lead Agencies promptly address issues to comply with Federal and State requirements. Lead agencies are given a Case File Compliance Worksheet at the end of each site visit which details the items out of compliance for each participant case file reviewed. They are required to correct these items and submit the worksheet to DHS within 60 days of the review. A majority of lead agencies have been able to submit their Compliance Worksheet within this timeframe, and although a few have requested short extensions, all lead agencies have brought their non-compliant cases into full compliance following their site visit. The corrected items are recorded in the case file review database to document remediation. Overall, lead agencies were able to correct nearly 100% of all items that appeared on their Compliance Worksheet. However, if a case has closed (e.g. the participant passed away or moved to another lead agency since the waiver review) the lead agency cannot bring the case into compliance. When these factors are considered, no cases reviewed remain non-compliant.

Internal and External Relationships

Case managers are connected to their communities and are aware of resources available to meet the needs of participants. Unique needs and plans of care may require case managers and assessors to navigate across different lead agency departments and units, as well as communicate with service providers and community organizations. In these cases, internal communication between different areas within a lead agency such as adult protection, child protection, mental health, and financial units can make it easier to provide seamless services for the participant. In addition, providers play a vital role in meeting the ongoing needs of the waiver participants they serve. The relationships and communication between the lead agency and providers are an important piece in ensuring participants' needs are being met and that they are satisfied with the services they are receiving.

Internal Relationships

In medium-sized and larger lead agencies, case managers work across departments and disciplines to serve participants. In some small lead agencies, case managers hold multiple roles in addition to waiver responsibilities, including intake, mental health and adult and child protection. Also, several lead agencies have structures where both Human Services and Public Health departments are managing waiver programs. Some lead agencies have also created

integrated teams of case managers that include both social workers and public health nurses. This structure allows staff to easily access the perspectives of both disciplines when serving participants.

Case managers across lead agencies indicated that when units are able to communicate freely and share information it creates a better system in which to serve participants. By working together with other units, case managers are better able to navigate the system and ensure participant needs are being met.

External Relationships

Although they may use different methods, most lead agencies are making an effort to monitor the performance of providers. It is important for lead agencies to provide oversight of providers and for their staff to ensure fulfillment of services outlined in the care plan.

- 71% of providers surveyed indicated they submit monitoring reports to the lead agency. These reports often include information about the participant's progress towards their goals and medical reports, and are included in the case file for case managers to reference.[13]

- 69% of lead agencies indicated that case managers always provide oversight to providers on a systematic basis.[14] Case managers shared that they make unscheduled visits to participants' homes and places of employment as a way to monitor providers.

- 87% of providers surveyed indicated that they receive the needed assistance when they request it from the lead agency most or all of the time.[15]

Case managers often work closely with providers and other organizations to ensure participants' health and safety needs are met. Case managers have worked to build strong relationships with providers, and are in frequent communication about the participants they are serving. This

[13] Data from provider survey.
[14] Data from quality assurance survey.
[15] Data from provider survey.

assures that providers are responsive to participants changing needs and will stretch to meet those needs.

During the waiver review, lead agency case managers were asked to rate their working relationships with local agencies serving participants in the community. Case managers are asked to only rate agencies they have had experience working with. Table 9 below shows the totals for rankings given by case managers. Overall, case managers ranked their working relationships with provider agencies serving participants as average to above average.

Table 9. Case Manager Rankings of Local Agency Relationships

Agency Type	N	Below Average	Average	Above Average
Vocational Providers	493	4%	37%	59%
Public Health programs for Seniors	84	8%	35%	57%
Foster Care Providers	564	2%	43%	55%
Advocacy Organizations	198	11%	39%	50%
Nursing Facilities	582	3%	48%	49%
Area Agency on Aging	146	14%	37%	49%
Customized Living Providers	372	5%	50%	45%
Home Care Providers	550	3%	55%	41%
Schools	358	7%	59%	34%
Hospitals	681	10%	62%	28%

When case managers elaborated on what made their relationships with providers good, they commonly stated that when providers had consistent staff they could build relationships and trust with those staff. This leads to improved communication and working collaboratively. Another reason case managers attributed to having a positive relationship was being invited to and attending meetings for the participant such as school Individualized Education Program (IEP) meetings or nursing facility care conferences. For lead agencies that assign case managers geographically, case managers noted that being assigned cases in this manner helped facilitate good relationships because they could really get to know specific organizations and their staff. For relationships that were not as positive, case managers often attributed this to limited choices of services and turnover in staffing, both at the lead agency and service provider. Case managers

also noted that a few providers have started to limit the number of waiver participants they will take. In addition, the lack of understanding by the provider's staff of the waiver program and the case manager's role contributes to poor relationships. Case managers also shared that several changes in 2014 put some strains on their relationships with providers, including 245D licensing, the end of lead agency provider contracts, and the implementation of the Disability Waiver Rate System.

Provider Service Capacity and Development

The mix of the rural and metro regions within the state means that provider capacity can differ greatly across lead agencies. The population size of lead agencies often dictates the amount of choice participants have in choosing their provider as well as the availability of specialized services. Although lead agencies are allotted limited resources, the waiver programs present the opportunity and flexibility for lead agencies and providers to develop new and creative services to target emerging needs and changing demographics.

Fifty-seven percent (57%) of lead agencies said that their agency recruits service providers to address gaps.[16] Lead agencies indicated that they often work with existing providers when developing services. Others indicated that they have used the Requests for Proposals (RFPs) or Requests for Information (RFIs) process to assess interest from current and new providers. However, with the end of lead agency contracts with providers in 2014, many have expressed uncertainty in how to best go about this moving forward. Some lead agencies have partnered with neighbors to increase purchasing power or share capacity in certain service areas.

Common Service Gaps

- **Twenty-five percent (25%) of providers said that transportation is a service gap.** [17] Transportation is frequently mentioned as a barrier to accessing services and a limitation to a participant's ability to participate in the community. In rural and suburban areas, public transportation options are either unavailable or have limited routes and hours of

[16] Data from quality assurance survey.
[17] Data from provider survey.

operation. For all low income waiver participants, cost may make it more difficult to access public transportation to travel to work or participate in other events.

- **Some vocational providers struggle to find community-based employment opportunities for their participants.** Providers surveyed chose community-based employment opportunities as one of their top service gaps (21%).[18] Many employment opportunities across the state are limited to center-based programs; however, some participants are able to work more independently in the community if the right training and supports are provided. Staff frequently shared that while they attempt to find community-based employment for their participants, there are limited options in most communities, and it is difficult to find opportunities that fit participants' needs and preferences.

Common Recommendations for Provider Service Capacity and Development

Develop more services or supports that allow participants to live in their own homes. This recommendation was given to 18 of 24 lead agencies (75%) in year one, 27 of 29 lead agencies (93%) in year two and only 19 of 30 lead agencies (63%) in year three. Lead agencies across the state are facing several changes that have prompted the need to pursue more independent housing options instead of more expensive residential placements. Statewide, lead agencies served 75% of EW and AC participants at home in 2013 which is the same as in 2011. The percent of DD participants served at home also remained the same from 2011 to 2013 (35%). However, the percent of CCB participants who are served at home has decreased from 63% in 2011 to 62% in 2013. [19] Also, providers responding to the provider survey indicated that another area for service development is the need to increase service options for participants residing in their own home (25%).

[18] Data from provider survey.
[19] Program summary data.

Lead agencies are encouraged to transition participants out of foster care settings to more independent housing options such as their own leased apartment with a roommate. Some lead agencies have begun to work with foster care providers to develop a continuum of services that include enhanced in-home service packages. However, progress has been slow. Supporting participants who are able to live more independently in their own homes should result in more space available in existing residential settings to serve those with a higher level of medical or behavioral needs in their own communities. In addition, freeing up beds in existing residential settings allows lead agencies to prepare for changes in the demographic profile of those they serve.

Best Practices: Establishing Effective Collaborative Practices of the Lead Agencies and Vendors for Person-Centered Practices

In the past, helping persons with disabilities obtain residential (e.g. corporate foster care) or employment services often meant researching existing available housing/employment options and referring the person to one or a few. To assure that services are developed where and when they are needed Dakota County has hosted local "innovations groups" or think-tanks comprised of lead agency staff, vendors of home and community-based services, and other stakeholders.

Innovations groups are mutual learning forums where best practices are shared and collaborative efforts are formed. For example, instead of selecting a single vendor to meet the person's service needs, multiple vendors have collaborated as a team to develop Individualized Service Options (ISO). People who had been declared impossible for any one vendor to serve, e.g. in foster care, are now doing well in their own homes with a team of vendors and natural supports.

Develop more community-based employment opportunities that result in higher wages for participants with disabilities. This recommendation was given to 22 of 24 lead agencies (92%) in year one, 22 of 29 lead agencies (76%) in year two, and 16 of 30 lead agencies (53%) in year three. In 2012, a Minnesota Statute was amended to require that information and resources for community based competitive employment be shared with everyone at the time of assessment. Enforcement of this requirement began in October of 2013, and since then, only 67% of case files of CCB working age participants (2,282) included information about employment, but 99% of DD case files for working age participants (518) included this information. Vocational

interests and abilities have historically been a part of the full-team DD screening process and document, while a question about employment was only recently added to the LTCC legacy template for the other HCBS programs. MnCHOICES includes an in-depth assessment of the participant's interests, strengths, and barriers in relation to working, volunteering, or opportunities for continuing education and training.

Between 2011 and 2013, the percent of working age participants earning $250 or more per month has increased slightly statewide. The DD program had 23% of working age participants earning $250+ in 2013, which is up slightly from 22% in 20011.[20] In the CCB program, lead agencies had 11% of working age participants earning $250+ in 2013, which is a slight increase from 2011 (10%).[21] The growing transition-age population not only impacts the need for independent housing, but also the demand for community-based employment options. Progress on this initiative has also been slow, and demand from waiver participants continues to exceed resources in many Minnesota communities. DHS suggests that lead agencies should be deliberate in developing these types of opportunities and set expectations with providers for the types of services that participants need to continue to increase income, expand their skills, build relationships, and maintain their independence.

Non-Enrolled Tier 2 and 3 Vendor Monitoring

Beginning in July 2014, lead agencies participated in a review of their practices for verifying that non-enrolled Tier 2 and 3 service vendors are qualified to deliver services. With the end of lead agency contracts for HCBS services effective January 1, 2014, this was a new requirement for lead agencies electing to use non-enrolled vendors. Since this change to DHS and lead agency operations was new, the review of the non-enrolled vendor monitoring process was meant to be educational and advisory; DHS did not issue corrective actions for the requirement at this time. However, if non-compliance was identified, the lead agency was asked to remediate any required documentation.

Of the 21 lead agencies reviewed since July 2014, 15 utilized non-enrolled providers. Those lead agencies primarily used non-enrolled providers for home modifications, chore services, and non-

[20] Program summary data.
[21] Program summary data.

medical transportation services. Staff frequently cited the lack of providers in rural communities as the most motivating factor for using non-enrolled providers. Therefore, in order to meet local needs and make these services available, the lead agency must use the lead agency-affiliate vendor arrangement and act as a pass through billing agent. Lead agency staff also shared that many of their smaller providers were either unable or unwilling to go through the MHCP enrollment process.

The majority of lead agencies who participated in a lead agency waiver review had either a supervisor or lead worker who managed the vendor credentialing process for non-enrolled providers. Although no lead agency was found to be in complete compliance with documentation requirements, most utilized some form of a Service Purchase Agreement (SPA) developed by either DHS or the lead agency. Common issues included the lack of an SPA, the SPA not containing all required elements, and the SPA not being signed by both the vendor and lead agency prior to the claim start date. Many lead agencies were also aware that they needed to maintain a log of their non-enrolled vendors, but failed to utilize their log to properly document that they had verified that the vendors were not on the CMS or MHCP Exclusion Lists and had certifications applicable to the services they were to provide.

Waiver Allocations & Management

Overall, lead agencies manage their allocations well; lead agency staff takes a close look at participant needs, availability of services, and the need to manage risk as they make funding decisions. All lead agencies review participants on waiting lists periodically and use a prioritization system to add participants to the waiver when funds are available. An adequate amount of reserves varies from lead agency to lead agency, as smaller lead agencies need a higher percentage of funds to protect themselves.

Over the past three years, the Lead agency Waiver Review has observed more lead agencies merging their allocations with neighboring lead agencies to form waiver alliances. These types of arrangements allow lead agencies to spend more of their allocated HCBS budget while being protected in the event of a high cost participant or crisis. As an alliance, counties have been able to meet participant needs and manage risks in a way they were unable to do as smaller agencies managing waiver allocations on their own. Waiver alliances have also allowed lead agencies to

build relationships and conduct regional planning to enhance services for participants. Additonally, case managers from these agencies have been able to specialize and access other case managers as part of the broader network within the region.

Best Practice: Regional Waiver Alliance

Forming a waiver alliance often allows small to mid-size lead agencies to better manage their risk with the desire to meet the needs of its community members. There are many types of alliances and many ways to structure a waiver alliance. One example is the Region 6W Waiver Alliance which includes Swift, Big Stone, Chippewa, Lac Qui Parle, Swift and Yellow Medicine Counties. The alliance was formed in 2013 for the DD and CCB waiver allocations. Each lead agency continues to receive its own allocation, but must get approval from the alliance to authorize funds over 97% of its total allocation. With the help of the alliance, Swift County (reviewed in 2014) was able to increase its CADI program enrollment in order to meet the high level of demands in the county.

Common Recommendation for Waiver Allocations

Some lead agencies have room in their budgets to enhance services or add participants to programs. This recommendation was given to 46% of year one agencies, 34% of year two agencies and 30% of year three agencies. Lead agencies who received this recommendation typically had a more than adequate allocation reserve to manage risk of high cost participants while also providing needed services to current participants. Lead agencies are encouraged to explore ways to spend the additional funding by not only reducing waitlists or adding new participants, but also to add services that enhance the quality of life, such supportive employment to help participants find meaningful community-based work or achieve other positive outcomes. Some lead agencies have found that bringing in business or accounting staff expertise to help with managing waiver allocations has worked well, as they can often provide additional trend analysis above and beyond the Waiver Management System.

Table 10 shows the frequency distribution for lead agency budget reserves. Twenty-seven percent (27%) of Round II lead agencies had a DD budget reserve between 10% and 15% at the time they were reviewed. It was also common for CCB budget reserves to be between 10% and 15%; however, 37% of lead agencies had a reserve of 16% or more in FY 2012.

Table 10. Number of Round II lead agencies with waiver budget reserves at the time of review[22]

Program	3% reserve or less	4% to 6%	7% to 10%	10% to 15%	16% or more
DD	9	19	23	22	8
CCB	6	10	17	18	30

Feedback on DHS Resources

Another goal of the Lead Agency Waiver Reviews is to gather information from lead agency staff about their use of and feedback about various DHS resources that are available to help in the administration of the HCBS waiver programs. This information provides constructive feedback to DHS to improve efforts to provide ongoing technical assistance to lead agencies. Through interviews with staff and the case manager focus group, the waiver review was able to gather data about the benefits and challenges to using different resources. Table 8 below shows the final dot voting results from the focus groups. Case managers only rated resources they have had experience working with.

Table 11. Case manager rankings of DHS resources (Scale: 1= Not Useful; 5= Very Useful).

		Rating	Rating	Rating
DHS Resource	**N**	**1-2**	**3**	**4-5**
E-Docs	703	6%	13%	80%
Senior Linkage Line	484	11%	20%	70%
Disability Linkage Line	392	11%	25%	63%
Community Based Services Manual	530	10%	30%	61%
Help Desk	420	20%	28%	53%
Ombudsmen	507	19%	30%	51%
Regional Resource Specialist	427	24%	26%	50%
Bulletins	742	17%	34%	49%
Videoconference trainings	727	20%	38%	43%
DB101.org	134	30%	28%	41%

[22] Does not include White Earth and Leech Lake

Listserv announcements	388	21%	38%	41%
Policy Quest	378	31%	27%	41%
DHS website	721	21%	38%	41%
Webinars	691	25%	38%	37%
MinnesotaHelp.Info	304	31%	33%	37%

Case managers ranked E-Docs as a very useful tool to their work with the waivers because it is a main source for finding updated forms. Case managers also shared that they refer participants to the Senior Linkage Line and Disability Linkage Line for information about benefits or services, and often use these resources themselves. Case managers and supervisors that work with the Regional Resource Specialist (RRS) appreciate having one person to connect with for questions. They report that the RRSs are responsive and they appreciate attending quarterly meetings and hearing about program updates.

Supervisors and case managers both use the Community Based Service Manual (CBSM), formerly the Disabilities Services Program Manual (DSPM), and have found it helpful for answering their basic questions about the waiver programs. It has been especially useful for new staff to reference for general information while learning about the waiver programs. Many case aides and case managers who enter screening documents have found the MMIS Help Desk to be a very useful resource stating that they provides timely responses to their questions. However, some case managers said that delayed responses can be common. While many case managers have varied experiences with the Ombudsmen, those who have had positive experiences said that the ombudsman does a good job acting as a mediator and serving as an advocate for participants by attend their meetings and issuing follow-up reports. While many case manager have not used DB101.org those who have said it has been a great resource for families with transition age children and for adults who are interested in learning how employment will affect their benefits.

Lead agency staff also offered criticism of some of the resources. For example, both case managers and supervisors shared that the DHS website is difficult to navigate and that the search function does not always yield helpful results. However, many case managers added that the website has improved significantly over the past year. While videoconferences and webinar trainings are valued by lead agencies, the staff have shared that they have had technical issues

with the trainings and that the information shared is not always current or is difficult to put into practice. Lead agency staff use Policy Quest, but it is common for only a few staff to have access to submit questions. Case managers have shared that the responses received from Policy Quest can be difficult to interpret and conflict with past responses. While they often browse questions that have already been asked to answer their own questions, they do not always obtain the answer they need. While some case managers said that MinnesotaHelp.Info can be a useful tool for finding different community resources many case managers added that it is not easy to navigate or search and it does not always contain up-to-date information.

Follow-Up Results

Approximately one year after conducting the on-site waiver review, DHS sends a brief survey to each lead agency. This allows DHS to learn about changes happening at the lead agency, monitor ongoing compliance with corrective actions, and continue to build relationships with lead agency staff.

Of the 83 lead agencies visited, 55 have submitted a follow up survey as of May 2015. The remaining 28 will receive and submit their survey over the course of the next year. The findings include:

- Of 312 recommendations issued to these lead agencies 40% have been implemented; 39% are in the process of being implemented in the near future, and; 21% have not been implemented. Lead agencies commonly cited the following reasons for choosing not to implement recommendations: electing to focus on other HCBS initiatives; limited staff time and resources; and a lack of qualified service providers.

- Of 194 corrective actions issued to these lead agencies 94% have resulted in a compliant practice. However, one year later 12 or 6% of the corrective actions had not yet resulted in compliant practices at a few lead agencies. Lead agencies acknowledging on-going struggles are asked to update their corrective action plans and DHS will continue to monitor their progress.

- Lead agency staff want to be compliant with programmatic requirements and work hard to correct areas of non-compliance when it's brought to their attention. When asked how lead agencies know their practices have come into compliance, they report using a variety of techniques to self-monitor. The most common are internal case file audits conducted by supervisors or peers and modifications made to document templates to include required components.

Continuous Improvement Efforts Within DHS

As noted earlier, lead agency waiver reviews gather feedback from directors, supervisors, assessors, and case managers about DHS resources. While on-site during the reviews, observations are also made regarding barriers to lead agency compliance. The Lead Agency Waiver Reviews will continue to serve as key connector between lead agency program staff and DHS policy staff for communicating ongoing concerns as changes are made at DHS and with the HCBS programs.

Over the past three years, here are some examples of how these learnings are passed onto the proper areas within DHS to prompt improvements, big and small.

- Forms were updated to include additional program requirements and allow for easier compliance. As program requirements change in Minnesota Statute or the federally approved waiver plans, some of these changes may not be updated in all DHS document templates, particularly those that are optional for lead agencies. Examples include the CDCS Community Support Plan (DHS 6532), Related Conditions Checklist (DHS 3848A), and the legacy LTCC assessment tool (DHS 3428).

- While many programmatic requirements cannot be eliminated based on lead agency feedback, some adjustments can be made or those requirements can be better communicated to promote compliance. Information obtained from lead agencies during waiver reviews has led to updates to the CBSM to clarify requirements (e.g. appeal and privacy practices information). It has also lead to modifications to service standards, including the proposed waiver amendment to allow lead agencies to use non-enrolled vendors for vehicle modifications, as all MHCP enrolled providers are located in the metro.

- Improved collaboration is sought amongst external partners of DHS. Many lead agencies provide contracted care coordination for Managed Care Organizations (MCOs) for EW participants. Those lead agencies and those participant case files are subject to both the MCOs audit and the DHS Lead Agency Waiver Review, but the list of which compliance items are verified varies. The Lead Agency Waiver Review continues to share its protocols and findings with MCOs to better align audit protocols. MCOs have also modified the collaborative care plan template to better address additional requirements.

- Additional support was provided to four lead agencies identified as needing additional guidance and monitoring to ensure that they were in compliance with waiver program requirements. Follow up site visits were made to these lead agencies approximately one year after their initial review. DHS reviewed another sample of their case files at that time and evaluated any changes the lead agencies had made to their business practices. Thanks to the commitment of the staff, compliance at these lead agencies significantly improved in just one year.

Conclusion

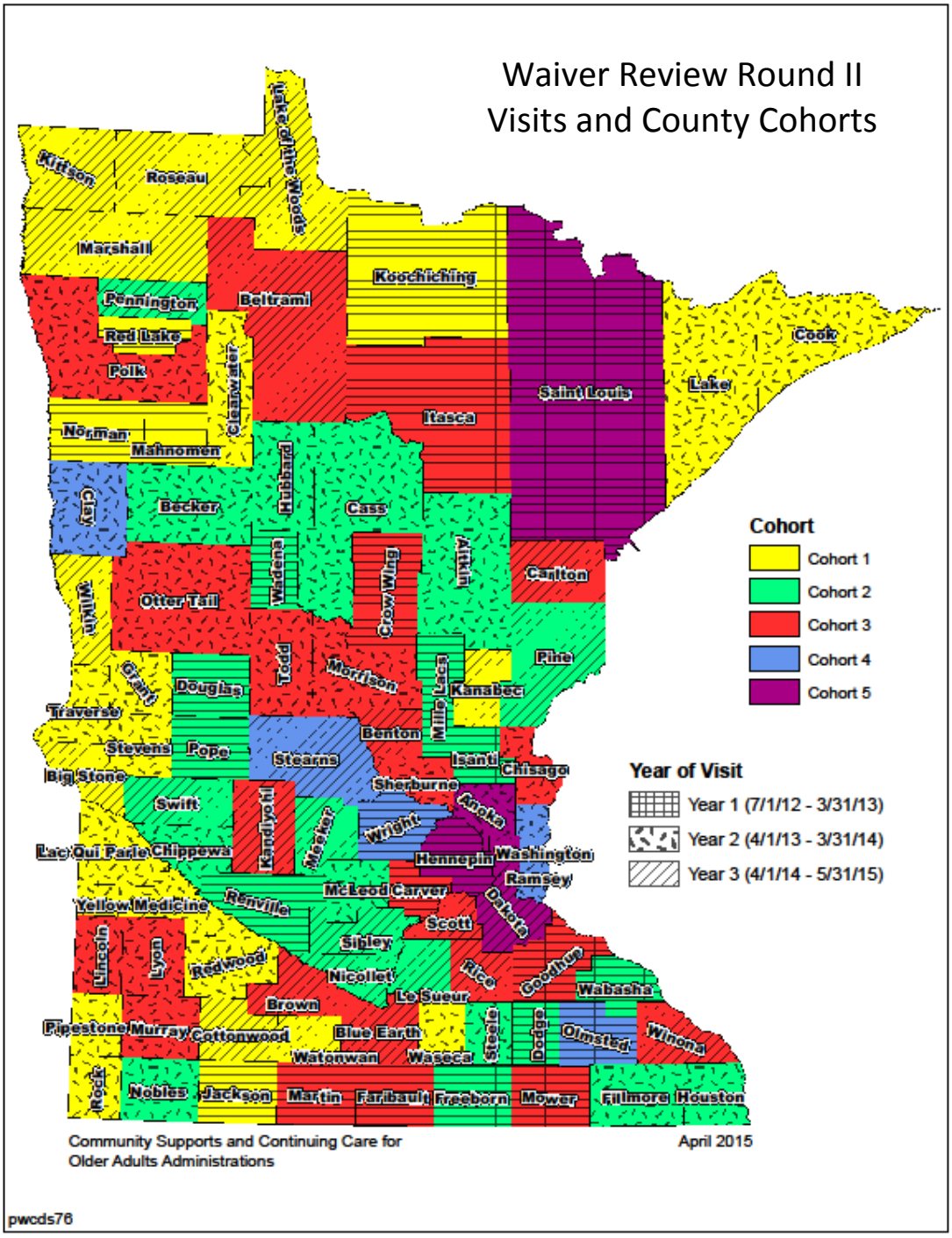
Over the past three years, DHS has completed the second round of site visits for the Lead Agency Waiver Review. This included all 83 lead agencies in Minnesota, which are comprised of 87 counties and two tribal nations. Multiple data collection methods were used to assess the administration of the waiver programs. In addition to assuring compliance, DHS also identified strengths and promising practices in serving elderly and disabled participants across the state. Lead agencies are providing quality case management to participants, and case managers and other lead agency staff are connected to communities and providers.

Through the review process and conversations with lead agency staff at all levels, DHS has also identified some areas that lead agencies could improve upon. Increasing caseloads and the complexity of the waiver programs have created a need for additional case manager support so they can focus on continuing to provide quality case management and care planning. The past few years have also been a time of significant change in the administration of HCBS programs including the implementation of the Disability Waiver Rate System (DWRS), MnCHOICES, and changes to Nursing Facility Level of Care. The changes posed additional challenges for lead

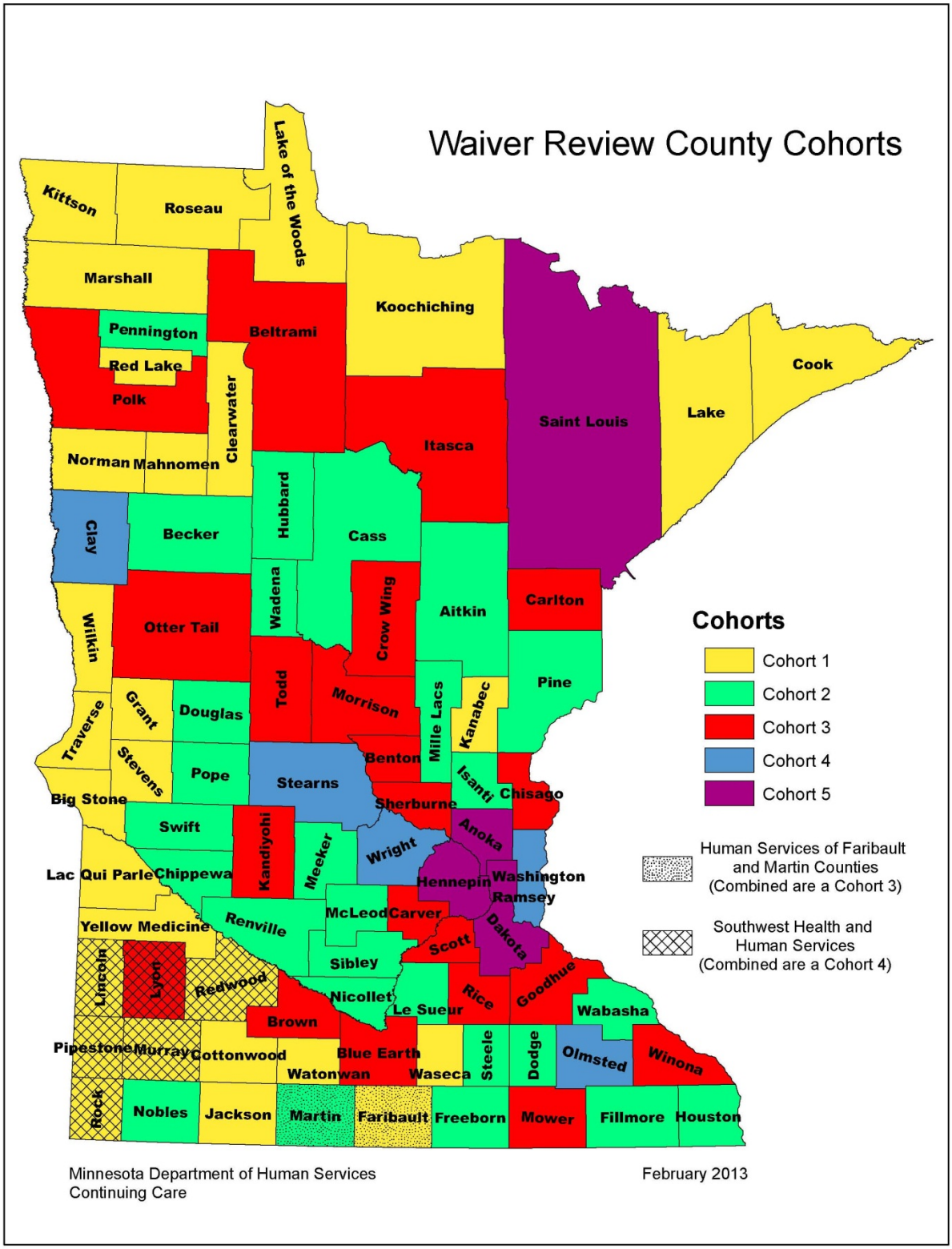
agencies and required them to allot a significant portion of staff time to training and adjustments to existing practices. Finally, lead agencies also continue to struggle to fill specific service gaps. DHS encourages lead agencies to work closely with providers, their communities, and other lead agencies to share practices and collaborate in developing services that benefit all participants.

Appendix A: Waiver Maps

Map of Minnesota counties reviewed in Round II of the HCBS Waiver Review.



Map of all Minnesota counties by cohort.



Appendix B: Dashboards

Below are the Waiver Review Performance Indicator Dashboards with results from the 83 Lead agencies reviewed in Round II. Dark grey shading indicates a required compliance item.

Scales for Waiver Review Performance Indicator Dashboard

Strength: An item on the Waiver Review Performance Indicator Dashboard is considered a strength if the lead agency scored 90% to 100% on the item, outperformed its cohort, or self-reported a compliant practice in alignment with DHS requirements or best practices. Items are green when considered a strength.

Challenge: An item on the Waiver Review Performance Indicator Dashboard is considered a challenge if the lead agency scored below 70%, is being outperformed by its cohort, or self-reported a non-compliant practice regarding DHS requirements or best practices. Items are yellow when considered a challenge.

PR: Program Requirement

CCB: A combination of the CAC, CADI, and BI waiver programs

	CCB	CCB	CCB	DD	DD	DD
Participant Access (By Year)	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
# of participants waiting for HCBS program services	1,211	1,350	1,447	3,551	3,562	3,499
Percent of program need met (enrollment vs. waitlist)	96%	96%	96%	85%	85%	86%

System Performance (By Year)	AC / EW 2011	AC / EW 2012	AC / EW 2013	CCB 2011	CCB 2012	CCB 2013	DD 2011	DD 2012	DD 2013
Percent of LTC recipients receiving HCBS	66%	67%	68%	94%	94%	94%	92%	92%	92%
Percent of LTC funds spent on HCBS	42%	43%	45%	88%	88%	89%	87%	87%	88%
Percent of waiver participants with higher needs	55%	58%	60%	78%	79%	79%	84%	86%	85%
Percent of waiver participants served at home	75%	75%	75%	63%	63%	62%	35%	35%	35%
Percent of working age adults employed and earning $250+ per month	N / A	N / A	N / A	10%	11%	11%	22%	22%	23%

Participant Access (Round II)	All	AC / EW	CCB	DD
% screenings done on time for new participants	76%	77%	65%	93%
% face-to-face screening (CCB) or full team screening (DD)	N / A	N / A	55%	78%

System Performance (Round II)	All	AC / EW	CCB	DD
Percent of required HCBS activities in which the LA is in compliance (QA survey)	98%	N / A	N / A	N / A
Percent of completed remediation plans summited by LA of those needed for non-compliant items (QA survey)	100%	N / A	N / A	N / A

Provider Capacity & Capabilities	Always	Most of the time	Some of the time	Never
Case managers provide oversight to providers on a systematic basis (QA survey)	69%	17%	11%	4%
Case managers document provider performance (QA survey)	71%	23%	5%	1%

Provider Capacity & Capabilities	All
Percent of providers who report receiving the needed assistance when they request it from the LA *(Provider survey, n=1,411)*	87%
Percent of providers who submit monitoring reports to the LA *(Provider survey, n=1,411)*	82%

Lead Agency Utilization of Non-Enrolled Vendors	ALL
Service incidents in which lead agency maintained all required qualification documentation for Tier 2 vendors (PR, n=86)	1%
Service incidents in which lead agency maintained all required qualification documentation for Tier 3 vendors (PR, n=17)	12%

Case File Results

Person-Centered Service Planning & Delivery	ALL Initial	ALL Follow Up	AC/EW Initial	AC/EW Follow Up	CCB Initial	CCB Follow Up	DD Initial	DD Follow Up
Timeliness of assessment to development of care plan (PR)	95%	N / A	97%	N / A	94%	N / A	N / A	N / A
Care plan is current (PR)	99%	100%	99%	100%	98%	100%	98%	100%
Care plan signed and dated by all relevant parties (PR)	98%	100%	98%	100%	97%	100%	98%	100%
All needed services to be provided in care plan (PR)	94%	100%	94%	100%	92%	100%	97%	100%
Choice questions answered in care plan (PR)	96%	100%	97%	100%	93%	100%	99%	100%
Participant needs identified in care plan (PR)	76%	100%	72%	100%	72%	100%	92%	100%
Inclusion of caregiver needs in care plans	55%	N / A	43%	N / A	52%	N / A	100%	N / A
OBRA Level I in case file (PR)	98%	100%	99%	100%	96%	100%	N / A	N / A
ICF/DD level of care documentation in case file (PR for DD only)	94%	100%	N / A	N / A	N / A	N / A	94%	100%
DD screening document is current (PR for DD only)	98%	100%	N / A	N / A	N / A	N / A	98%	100%
DD screening document signed by all relevant parties (PR for DD only)	92%	100%	N / A	N / A	N / A	N / A	92%	100%
Related Conditions checklist in case file (DD only)	56%	99%	N / A	N / A	N / A	N / A	56%	99%
TBI Form	87%	100%	N / A	N / A	87%	100%	N / A	N / A
CAC Form	86%	100%	N / A	N / A	86%	100%	N / A	N / A

Person-Centered Service Planning & Delivery (continued)	ALL	ALL	AC/EW	AC/EW	CCB	CCB	DD	DD
	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up
Employment assessed for working-age participants	67%	100%	N / A	N / A	58%	100%	100%	N / A
Need for 24 hour supervision documented when applicable (EW only)	79%	99%	79%	99%	N / A	N / A	N / A	N / A
PARTICIPANT SAFEGUARDS	**ALL**	**ALL**	**AC/EW**	**AC/EW**	**CCB**	**CCB**	**DD**	**DD**
	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up
Participants are visited at the frequency required by their waiver program (PR)	94%	100%	86%	100%	97%	100%	88%	100%
Health and safety issues outlined in care plan (PR)	88%	100%	85%	100%	87%	100%	98%	100%
Back-up plan (Required for EW, CCB, and DD)	79%	100%	77%	100%	89%	100%	67%	100%
Emergency contact information	97%	100%	97%	100%	99%	100%	95%	100%
PARTICIPANT RIGHTS & RESPONSIBILITIES	**ALL**	**ALL**	**AC/EW**	**AC/EW**	**CCB**	**CCB**	**DD**	**DD**
	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up	Initial	Follow Up
Informed consent documentation in the case file (PR)	92%	100%	91%	100%	92%	100%	92%	100%
Person informed of right to appeal documentation in the case file (PR)	71%	99%	69%	99%	59%	99%	94%	100%

Person informed privacy practice (HIPAA) documentation in the case file (PR)	88%	100%	89%	100%	88%	100%	88%	100%
PARTICIPANT OUTCOMES & SATISFACTION	**ALL**	**ALL**	**AC/EW**	**AC/EW**	**CCB**	**CCB**	**DD**	**DD**
	Initial	**Follow Up**	**Initial**	**Follow Up**	**Initial**	**Follow Up**	**Initial**	**Follow Up**
Participant outcomes & goals stated in individual care plan (PR)	92%	100%	91%	100%	91%	100%	97%	100%
Documentation of participant satisfaction in the case file	44%	N / A	44%	N / A	43%	N / A	46%	N / A

Appendix C: Technical Compliance

The following table displays the corrective actions issued to a lead agency and the number and percent of lead agencies that received the corrective action in Round II. This table does not include the corrective action plans for White Earth, Leech Lake, or DVHHS. Outstanding corrective action plans that were not due at the time of the report are included in footnotes.

Corrective Action	N of Lead Agencies Receiving Corrective Action	% of Lead Agencies Receiving Corrective Action	% of Corrective Action Plans Received[23]
Persons Informed of right to appeal documentation in the case file	49	59%	100%
Persons Informed of privacy practice (HIPAA) documentation in the case file	30	36%	100%
Timeliness of LTCC Assessments	30	36%	100%
Back-up plans	19	23%	100%
Care plan signed and dated by all relevant parties and Choice questions answered in care plan	16	19%	100%
Frequency of visits as required by program	16	19%	100%
Informed consent documentation in the case file	13	16%	100%
Employment assessed	12	14%	100%
Related Conditions checklist in case file (DD only)	11	13%	100%
BI Form	9	11%	100%
Care plan is current	8	10%	100%
DD screening document signed by all relevant parties (DD only)	8	10%	100%

[23] This does not include White Earth, Leech Lake, or DVHHS due to their Corrective Action Plans not being due until after this report was issued. All outstanding Corrective Action Plans will be submitted by June 2014.

Corrective Action	N of Lead Agencies Receiving Corrective Action	% of Lead Agencies Receiving Corrective Action	% of Corrective Action Plans Received[23]
Documentation of need for 24 hour supervision in customized living for EW program	6	7%	100%
Timeliness of assessment and individual care planning	5	6%	100%
Current DD screening	5	6%	100%
Develop a caseload management plan that assures compliance of all waiver programs	4	5%	100%
OBRA Level One	4	5%	100%
ICF/DD level of care documentation in case file (DD only)	3	4%	100%
CAC application	3	4%	100%

Appendix D: Recommendations for Lead Agencies

The following tables display the most common recommendations issued to lead agencies and the number and percent of lead agencies that received the recommendation in Round II.

Case Management

Recommendation	Suggestions	N of Lead Agencies Receiving Recommendation	% of Lead Agencies Receiving Recommendation
Use visit sheets during face-to-face visits with participants	Document provider performance Monitor participant satisfaction with services	53	64%
Develop lead agency systems or practices to support case managers	Designate a lead case manager Create formal systems for training new staff and maintaining case file documentation Hold regular waiver meetings with staff	39	47%
Use contracted case management services to serve participants	Assign distance cases to a contracted worker to reduce travel Provide cover during staff shortages Can provide access to culturally appropriate services	37	45%

Assessment and Care Planning

Recommendation	Suggestions	N of Lead Agencies Receiving Recommendation	% of Lead Agencies Receiving Recommendation
Update care plan formats and expectations for completion to ensure they are person-centered	Use participant-friendly language Help develop goals that are individualized and meaningful	25	30%
Include service details in care plan	Include the provider name, type of service, frequency, unit amount, monthly budget, and yearly budget	25	30%

Provider Service Capacity and Development

Recommendation	Suggestions	N of Lead Agencies Receiving Recommendation	% of Lead Agencies Receiving Recommendation
Develop services that allow participants to live in the least restrictive setting possible in their own communities	Explore services such as assistive technology, home modifications, independent living skills, chore/nursing services, and in-home support.	64	77%
Develop more community-based employment opportunities for participants	Move away from center-based options Develop community opportunities result in higher wages for participants	60	72%

Waiver Allocations and Management

Recommendation	Examples	N of Lead Agencies Receiving Recommendation	% of Lead Agencies Receiving Recommendation
Use budget reserves to enhance services or add participants to programs	Enhance supportive employment or in-home services Include accounting staff in allocation meetings	30	36%