

Provider Meeting February 2, 2016
AEDD Community Room
Little Rock, AR
Total of 166 attendees including DDS employees

Case Management Questions/comments suggestions regarding regulation

The National Core Indicators stated, "Although the state's system is based on full freedom of choice of case management agency, only 53% of respondents indicated they chose their case manager." This is a bogus finding because even if you had conflict free case management people will not be able to choose their case manager-these same individuals cannot choose their doctor-only doctors who participate in Medicaid. 90% say case managers helped with getting what they need or want. This is an awesome figure. To say we are changing the way we do business because of data from one state is ridiculous.

Where do statistics come from as far as 33% indicate making changes to services and 53% freedom of choice for case managers?

How can policy be set based on NCI in ONE state regarding case management services? What do the other states show?

Who chose 47% of the respondent's case manager if they did not? Isn't choice made at the administrative level (DDS?)

On CMS slides it says data was based on 1 state NCI results. What is the data showing for the other 49 states? Does it show the same data?

Handout with page 21 on it identifies what state must do to mitigate conflict. We do all of the items listed on the page-therefore our congressional delegation should request clarification before changes are made.

My major concern with splitting case management and supported living services is that we will lose the intimacy that we have with our clients and that in turn is going to make writing their plans harder.

The consumers in the group homes and provider supervised apartments that have been living in the residence for years and are comfortable, give them choice of case management only so they can remain in their homes.

We would like to see waiver use only Medicaid regs {regulations} instead of extra regs {regulations} to help with time restrictions.

What constitutes an "interest" a case manager would have in a service provider?

What are the barriers to establishing a case management entity?

Are all case managers able to provide services throughout the state? If not, who are the ones who do?

Have CMS representatives come to Arkansas to meet with provider representatives and state agency representatives and congressional delegation members to arrive at an approvable conflict-free case management system.

Questions/solutions (Administrative authority)

Why can't DDS provide Case Management?

Could DDS take over the case management role?

Why can't the DDS Specialist fill the case management position to fulfill the "conflict free case management"?

Is there a process in place to review when the only willing and qualified case manager is affiliated with the direct service provider?

DDS Develop standardized forms to obtain information sharing between Case Management Direct Service Providers-information required for plan of care; shared quarterly-consistent with outcomes, frequency of review

State ran electronic program for all providers so files are consistent for both providers input.

Phase-in PCSP dates (start 3-6 months prior to plan end date). What about using a center-wide office database system run by the state.

What are your plans to deal with the massive number of transition plans that will occur when dealing with conflict free case management?

Delete case management, give waiver coordination more duties-no conflict.

In order to separate case management services from waiver coordination, case management reimbursement must increase.

Suggestions/solutions (external to administrative authority):

Have you considered conflict free case management for all plans above a certain level (greater than \$75,000) (this represents 42% of waiver expenditures and 20% of beneficiaries)?

Phase in conflict free starting with pervasive level and going down from there as CSR comes due.

If SKYPE, face time etc., is used how do we guarantee HIPPA compliance if it is not secure?

Delete case management, give waiver coordination more duties-no conflict

Is tele-case management an option?

Assessments by private agency vs state agency doing the assessments. Supportive living agency can have the case management part/duties, but the state agency has the final decision on the plan.

Change definition of private assessment to case management functions. Leave service with waiver coordination- no conflict.

Look at self-directed case management-the goal is to cut and save. DDS do some training and pass out resources/ generic resources with advocacy group. Development of advocacy groups.

Set up Coops according to the regions. Each provider from region could nominate board members.
Problem-start-up funds for this.

Partner with local providers (or nearest provider) and swap case management for case management.
Have limit of 50-70 miles that they have to travel. This will keep provider in that area involved with local waiver individuals. This will keep financial impact of smaller providers limited.

One case management agency with substations local for each area.

Cooperative agreement between providers for case management services.

What about one of our state provider groups run a case management agency (AWA or DDPA)?

Oppose one entity performing case management services for the entire state. As an alternative, form a statewide cooperative of providers who share responsibilities for case management. Ideally, this would be based on regions of the state. Consumer would be given the option of case management with exception of current supportive living provider (Providers basically provide cm for each other, but limits choice). A Case management only entity would require a much higher reimbursement rate than the current 117.10/month. This would require a drastic rate increase to work.

Drop case management from waiver-go to targeted case management only.

Open enrollment modeling EC.

Case managers like the formal targeted case manager.

Offer choice-can't choose both so must have 2 agencies-all agencies provide case management but no to person who rets direct care

Call state worker's case managers. Private entities do waiver coordination-no conflict

Less paperwork for DDS Specialist=case management on waiver specialist. The state hire or contract an outside source to provide case management services.

DDS Waiver specialist do case management and current provider case managers would become care coordinators/liasons with funding level.

Waiver specialist do all case management. Saving on monthly case management fee would fund new specialist slots. If a study is done and there are savings new waiver slots could be created off waiting list.

Redefine case management-make changes to definition of case management so that they only have to access services.

DDS can do case management.

State agency have the responsibility of providing case management.

Case Management done by the state or out-sourced.

Stagger transition to conflict-free case management with 1st wave being high dollar plans/pervasive level of care. Develop time line to identify assessment tool that can identify with fidelity needs of

beneficiaries and develop corresponding funding tiers. Once this is in place, change to care coordination.