**MACDDS Medicaid Waiver Work Group Meeting**
**Jefferson City, Missouri**
**January 24, 2008**

**In attendance:** Kit Glover and Sandra WiseWise (DMH), Roger Garlich (Chair), Alecia Nissen, Jan Jones, Doris Boeckman, Betsy Barnes (by phone), Peg Capo (by phone) and Jane Kruse (by phone)

Roger made brief introductions and summarized the purpose of the group, then turned the meeting over to Jane Kruse. Purpose: 1) learn about Medicaid and waivers; 2) research innovative ideas in other states and DRA; 3) develop recommendations to DMH and others

Jane referenced the handouts. Following are specific comments made related to various state programs.

Wisconsin and Ohio – very strong county-based programs; similar to Missouri.

**Medicaid Waiver Summary:**

- Service has to be sufficient in amount, duration and scope to reasonably achieve its purpose.
- Coverage services must be offered statewide (statewideness)
- Comparable among eligibility groups – can be waived for targeted case management, but most need to be comparable
- Choice of providers
- Certain benefits must be provided to all – mandatory services;
- Others are optional

Single state agency cannot delegate responsibility – but can enter into cooperative agreements to administer certain aspects. This is why State Plan Amendments or waiver requests must go through Medicaid program (a/k/a Mo Healthnet). Missouri Medicaid has an agreement with DMH.

State Plan is group of preprinted documents that State has to fill out. Choices that need to be made. This is the contract between the Medicaid program and federal government. Typically, Amendment has to be submitted to Governor or designee. The process – if you have SPA or waiver request – it gets submitted to CMS – 90 days to take action. In almost every case there is a request for additional information. If so, they have an additional 90 days.

**Recommendation.** There is no federal requirement that the state give public notice if making SPA amendments. Possible that they are submitted without provider input. This is one area for recommendation – have a workgroup that is recognized by DSS and/or DMH to work with them prior to the time amendments are submitted so there is some time for input before amendments are submitted.

**Medicaid Waivers**

Allows state to waive some portion of the laws. Certain rules can be waived, some cannot. There are different waiver opportunities –

- 1115 demonstration and research – different process than 1915
- 1915
- Missouri has some of both

1915 Section b waivers – Freedom of Choice waivers – allow mandatory enrollment of medical recipients into managed care – MC+

1915 c – community based services as alternative to institutional care. These are the focus of the research.

States have a variety of ways to contain costs implementing these waivers to maintain cost neutrality. Federal spending for home and community based care cannot exceed what it would have cost if the individuals had been in institutional care. Can have a cap (fixed amount) or average amount. Missouri uses the average amount.

Under 1915c authority, there are a list of services in federal regulation that may be provided. Those are set out in the paper – case management, homemaker, home health.

Also an opportunity to request other services – as long as cost effective, necessary to avoid institutionalization and approved by CMS – can be waivered services. There have been a lot of other services. Jane is looking at what other states are offering.

New Mexico has a number of unique services – not sure how they afford to do some of those things.

**Deficit Reduction Act – opportunity to provide home and community based services in State Plan, and not submit waiver, but services are limited to ones listed in regulation.** Under this act, do not have to opt to have waiver services under DRA, still an option to have 1915 waivers. DRA is simply a new option for the state.

To manage cost in hcb waiver, states can put max $$ amounts on services and service limits that can be incurred by an individual.

1915 c waivers are approved for 3 years and can be extended for 5 years

Jane referenced comparison table on page 9 of the handout.

Jane had asked Kit for information on # of people receiving services in the waiver that aren't unique to that waiver. To identify people that could be moved from comprehensive to community support – there are some people that may not be in the right slots. People don't always want to give up that slot in case they need residential. Jane is looking at client rights and what legally would need to be done to move clients into waiver that best meets needs.

Kit said community support waiver inception was 2003 with 750 slots. At present it is at 1,034; she is in process of requesting additional slots up to 1287; 7,575 in the comprehensive. Large discrepancy in slots available. Some people in Comprehensive Waiver required in services and support that exceed $22,000 maximum. People are reluctant to transfer from one waiver to another – particularly with an aging population. Jane indicated it would not be a popular move, but one to still take a look at it.

Sandy stated that financially the slots would have to be backed.

7,460 slots were filled in the comprehensive waiver – need the money to meet the slots, particularly if all the individuals need residential.

Kit believed that DRA did not require budget neutrality.

Roger said part of the reason for doing this is county match dollars become available for any new services.

Sarah Lopez is 200 slots. Currently at 191. There is a waiting list for this.

1915 c in other states:
**Wisconsin** – Major restructuring initiative – moving people out of nursing homes; passed legislation that has been helpful; provide financial incentives to counties to move people out of nursing homes and ICF/MRs. Program called Enhanced Residential Program – 24 hour supervision and provides services to avoid nursing home placement.

**South Carolina** – fraud in program – when a personal care or respite provider goes to home for provision of services, must call in and must match the recipient's number when they get there; and when they leave – creates the billing statement.

Recruitment and retention of personal care workers – California did a few pilots. They established through Legislature public authority to partner with county to hire attendants. Help with recruiting and training; provide emergency workers if someone doesn't show up. Number of other states doing things in this area. A lot is related to providing health insurance to these workers; some offer coverage through what state has. Arkansas doing direct marketing with people with disabilities and those over 55 to provider personal care services.

Roger asked how many self direct in MRDD; Kit said a contract is under development for a new fiscal intermediary for self directed program that will require workers comp – health insurance not a part of it. Proposal is not released yet, but Workers Comp is an issue. May also be looking at electronic submission of time sheets.

Jane said not all of states were looking at self directed programs. Just looking at different ways to recruit and retain workers.

**Section 1115**
More demonstration models. 90 day rule doesn't apply. Novel, one-time pilot. Tested and then re-evaluated. Long negotiated process. Financial analysis is much more intense. The cash and counseling waivers and self-directed programs. Need some feedback in terms of priority. One state offers beneficiaries a cash allowance to purchase insurance on their own. Most beneficiaries do not want that responsibility.

**Deficit Reduction Act**
Tremendous amount of potential for change as a result. Fear is that states will ratchet down services. States do not have regulations for the most part, so it is hard to analyze the impact it has had. Some states are implementing the new features.

Targeted Case Management – may be a potential problem. "Federal financial participation is available for case management or targeted case management (tcm) if there are no other 3rd parties liable to pay for such services, including medical, social or educational program." This may prevent

services of tcm to foster children. The fear is the “any third party” – may not be able to provide the service or apportion the cost.

Under the new Medicaid transformation report it says everyone should have a health care home. The definition sounds exactly like tcm.

Fear is that under DRA language they will say Medicaid is paying for cm through the health care home so you can NOT bill tcm in addition to that. These conversations need to take place. There are two different projects going on -- the Chronic Care Improvement program – every Medicaid patient with certain chronic conditions. Oversight by Physician or APN. Conversations between DSS and DMH need to be occurring so SB40 boards don’t get left out of the loop.

Dr. Parks is working with DSS to define health care home. Roger spoke to Dr. Parks and Bernie – still gleaning information.

Kit explained there is an interim rule that tightens tcm. Comments were related to primary cm, what is considered cm; units of services; no bundling of services; conference call with directors of disabilities services. Other sates reeling from this.

**Recommendation.** Jane said Medicaid is having a very hard time getting physicians to enroll in Chronic Care Improvement program. Is it possible to identify within our population who they are seeing as their primary physician and then do service coordination like presently, but engage in a relationship with the local physician. Case management and health care home may be seen as duplication of services. Jane recommended a committee or a paper be developed that explains the roles of tcm and what that means if services are split up. Potential is there for problems with tcm. Needs to be a priority.

Kit indicated that some states have contracted with Conventry to present an argument against the interim rule.

**Benchmark Plans**
In most cases, people who are disabled or on SSI are exempt. Issues – some individuals are eligible under more than one category of assistance; people with disabilities can elect not to participate, but you can auto enroll with an option to opt out – both can be issues. State put together a plan of services comparable to what is offered by state or commercial carriers. Certain protections (EPSDT), mandatory age of benefits is reduced to under age 19 under DRA. Some might lose coverage if enrolled in one of the benchmark plans. The plans are not available to people on Spend-down or dual eligible or children under age 19. Not of great interest to population we serve because they can opt out and it is more of a commercial type insurance that doesn’t cover therapy and other services our population needs.

**Expanded HCB Services**
State can provide waiver services to people with disabilities up to 150% FPL without a waiver and without cost neutrality. Requires SPA. Needs based criteria. Set up functional eligible requirements. Anyone who meets them is eligible, depending on level of assistance needed. Can target by age or population. Criteria to qualify has to be level of care needs must be less than needing institution-alization. Vermont is going to use 1115 waiver to offer to individuals with moderate needs to see if it will help in delaying institutionalization. Limiting factor – can only provide services listed – knocks

out therapy and some of the services. State has a lot of flexibility. If utilization exceeds funding, state can adjust eligibility. Worry is the instability that would be created.

Iowa was first state to implement. Limited to serving to people with MI. May be good for children with dual diagnoses. Roger asked if MRDD would have to write the waiver or CPS? Some states are trying to establish a single point of entry. Need to have something totally separate for individuals who are dually diagnosed. Sandy felt they might be able to get the numbers. A lot of them are in psych hospitals and on the rolls.

**Family Opportunity Act** – Extend Medicaid coverage through purchase for under age 19 who meet eligibility standards and have assets at less than 300% FPL.

**Medicaid Eligiblity for SSI Beneficiaries -** Begins on whichever begins later – date filed or date granted. Used to be 1st day of month after date granted.

South Carolina – very high deductibles. Offers option to enroll in high deductible health plan to give beneficiaries a chance to participate in mainstream health insurance

**Managed Care –** Wisconsin has mandatory enrollment for persons seeking HCBS waiver services in participating counties doing something here. Different ways to implement these programs where putting providers at risk for providing long term care services. Problem is finding someone to do this. Managed care companies are reluctant to absorb risk. Ones who do it are nonprofit community based organizations in certain markets. Wisconsin uses county government as provider.

**Autism** – quite a few in place. In talking with Kit, major interest in Missouri. Number of kids in Lopez waiver receiving therapy services. Kit confirmed a lot of kids in Lopez waiver are autistic. Lot of these kids can't be served under exiting waivers, because they can't meet the level of services that require institutionalization.

Roger brought up the discussion about Children's Waiver related to First Steps. Concern that not enough children in First Steps qualified for Medicaid. The percentage is about 50%. It is a way to get more federal funds into the program.

When an individual is eligible for a waiver, they are then available to all SP benefits. So when additional eligibles are identified, the cost to cover all the SP benefits, must also be taken into account because it will drive up the Medicaid budget.

Medicaid Transformation Grant – re-evaluate the independent community living waiver, physical disability waiver – trying to get with Susan at DHSS to learn more.

Sandy indicated that DMH is looking at tightening eligibility rules.

Jane asked for a prioritization of the items. The following are the potential issues (not necessarily in priority order):

1) Identification of "other" services that could be included in existing or new waivers
    a. Peg agreed – example would be out-of-home respite care; there are some services that need a distinct rate structure and definition

2) Preventive Services for kids, particularly therapy, that could be in a community support type wavier
3) Recruitment and retention – College of Direct Support is under way, but still interested in looking at other states
4) Managed Care – risk based contract for long-term care services
5) Dual Diagnosis (MRDD/MI)
    a. Sandy indicated an interest in knowing how many MACDDS members are supporting individuals with dual diagnosis

**Other issues discussed** -- Children's waivers related to First Steps services to reduce amount of GR in First Steps program. The issue Peg raised about expanded eligibility based on her comment that a lot of people don't qualify. This ties in with the First Steps issue because expanded eligibility would increase Medicaid expenditures and reduce GR. This is an important area for review and education. Doris also suggested a speaker to give an overview of DRA as keynote at the MACDDS conference.

**Data**
Jane will get more data on the assisted living. Also need to make decisions on the health care home. Roger suggested Jane speak to Dr. Parks directly.

Other services and highly specialized services. Jane does not have a good feel for the services they want to provide that aren't currently provided or just a laundry list of what other states are providing.

Missouri has a program, Work Force Navigators. Charged to help people with dev disabilities. Jane wanted to know if this was GR or federal money. Employment was not discussed. A lot of funds not matched are for employment. Roger encouraged the work group to look at the CMS website and the services that states are providing under their waivers.

Utah has taken the lead on self employment issues nationally.

Meeting adjourned.