MACDDS Medicaid Waiver Work Group
February 27, 2008

Attending: Les Wagner, Betsy Barnes, Sandy Wise, Jane Kruse, Sandra Levels, and Doris Boeckman

Note: Kay Green will be returning to DMH March 10 as Federal Programs representative.

Doris mentioned that the MACDDS Conference Committee didn't think the DRA was the best topic for the conference. The conference is geared more toward direct service personnel.

Jane had talked with MOANCOR, specifically, Terry Combs. They have identified a few speakers for the MOACOR or Coalition conference. Nancy Thaler – NASDDS; Jim Conroy, Center for Outcome Analysis – study of Bellefountaine. Doris will touch base with Suzanne and Terry Combs about coordinating the speakers.

Jane also suggested that Sandy Levels discuss the case management definition, particularly, what is happening at the federal level. A bill was filed to place a moratorium on the case management regulation – so that no changes can be implemented for a year. However, the bill didn't pass both houses in Congress and the changes are supposed to go into effect March 3. Other states are filing lawsuits against CMS. Anything is possible.

Email from Community Mental Health Centers about contacting Congress about why not to do away with case management. If it goes into effect, what does that mean? Jane said she didn't see that it would eliminate case management, but it does make it clear that if a child is in foster care, there can't be any other case management – foster care must take care of them. There is a lot of speculation about interpretation. What MACDDS members are doing is not necessary going to be impacted dramatically.

Sandy Wise said that dual diagnosed individuals receive case management through CPS as well as MRDD. The regulations were implemented because some states were doing things they shouldn't have been doing – may be just to address the abuse that has been occurring.

Jane stated that at the last meeting there was discussion about First Steps. Jane followed up with DESE about Medicaid eligibles – the November and December 2007 eligible were at 39%. Les and Sandy Wise thought this percentage was low. Their budget doesn't show a lot of Medicaid revenue. Before Part(C) funds, Medicaid is to be billed first. She thought there should be more Medicaid revenue in the First Steps program. Sandy Levels asked for clarification. Sandy Levels felt that they (DESE) were bringing down adequate federal funds for the number of Medicaid eligibles. Jane suggested that a closer look be taken with someone familiar with the DESE budget.

Sandra Levels said that if the committee could pull together questions, she would be happy to work with DESE. Sandra asked that we give some clarification about what is meant by "Medicaid". PT, OT and speech, these are the only direct Medicaid covered services for which federal funds are drawn down. Jane asked if Sandy could tell through a special report what Medicaid funds were being spent on kids enrolled in the First Steps program (e.g., types of expenditures and types of services for which Medicaid has been paying). First steps has a unique provider number so Sandy Levels indicated she could do a claims comparison.

Les asked about DESE case management – it is not paid for by Medicaid. DMH case management is covered by Medicaid.

What are the therapy rates for First Steps? DESE operates under an OHCDS agreement – they can pay providers a higher rate. If they are paying their providers a higher rate, DESE is covering the additional cost. Medicaid only reimburses the Medicaid rate. There is an incentive for DESE to identify Medicaid eligible children because they can draw down federal funds.

Jane said there were two states that had targeted waivers for children in the Part C program. Pennsylvania and Nebraska – referenced the document prepared. Pennsylvania covers only one service – but it is a bundled service. CMS is not looking favorably on "bundled" services. They are serving about 5,000 children with no wait list. Disregard of parental income of some limit.

Nebraska – respite services and service coordination; disregarding family income. Respite is allowed at $100 per family per child. Family negotiates a rate of pay.

Expanded eligibility – need to look at who we are covering now and the gaps. At some point, we probably need to have DFS look at the eligibility summaries to make sure they are accurate. Jane referenced the prepared document. Covered SSI, SCHIP TEFRA, Expanded Eligibility Options, Medicaid Buy-In, DRA, and expanded EPSDT.

State of Connecticut has proposed expansion of its SCHIP program – it is administratively less burdensome than other options.

The buy-in program is attractive because it incentivizes families to keep their private coverage. Nice compliment to the SCHIP program. Many of the children need services that are not included in the private insurance programs.

EPSDT – it offers screening services for persons under 21, vision, dental, hearing and other…it is very comprehensive.

The Iowa program was of particular interest. Jane spoke with the director and wrote up a summary. It is operating in four different sites, covering 10 counties. Have minimum standards that have to be included in the screening tools.

Betsy asked about screening of children age 5. They are screening beyond First Steps at least in the four sites. If they are Part C eligible, they may be referred to a public health entity for services; a place for the provider to refer the family for additional services.

Jane referenced a study done by the National Academy for State Health Policy. She referenced the handout. Reports state that you need to have a well defined definition; look at codes, make sure services are age appropriate. May already have a vehicle through Medicaid through EPSDT to better define services needed – may not need a waiver; may be just maximizing what is already available to us.

Concern about whether managed care companies are serving children with EPSDT services. Families may not even be aware that they are entitled to the EPSDT services. Jane believes education in this area with families really needs to occur. Betsy asked about the frequency of screening requirements. Jane said there is a periodicity schedule.

Referenced a tool that has been developed by Georgetown University.

A discussion occurred about the 8-07 draft changes in the waiver manual; specific to personal assistance providers – current certification in CPR and first aid. Previously it said to have had training in CPR and first aid. Sandy Wise said she would have to review – she wasn't aware of the change. There isn't a standardization of communication on when changes to the waiver occur. Draft documents that revise documents – new documents that don't show the revisions. Recommend changes be made using something similar to what the Legislature uses. Many of the changes were procedure code changes. Medicaid uses a listserv to communicate with providers on changes.

Betsy suggested that the SB 40 TCM group should discuss how to better encourage families to use EPSDT screening tool.

Sandy Levels suggested that families need to know what EPSDT is. The Periodicity Schedule is compiled by the American Academy of Pediatrics and DHHS (federal level). An EPSDT screening is an annual physical in accordance with the periodicity schedule. It can be a tool for additional services if the child receives the well child checks and a need is identified during the exam.

Jane stated she would touch base with Roger on a list of programs that might be of interest for topics for the conference.

The group agreed to tentatively hold March 26 at 10 a.m. for the next meeting if a meeting was necessary.