Legislative Services Agency

MINUTES

Medicaid Elderly Waiver Program Study Committee

November 13, 2008

MEMBERS PRESENT:

Senator Amanda Ragan, Co-chairperson
Senator David Johnson
Senator Becky Schmitz
Representative Lisa K. Heddens, Co-chairperson
Representative David Heaton
Representative Thomas J. Schueller

MEETING IN BRIEF

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I. Procedural Business

Convening and Adjournment. The Medicaid Elderly Waiver Program Study Committee meeting was called to order at 9:04 a.m. on November 13, 2008, in Room 22 of the Statehouse. Roll call was taken and a quorum was determined to be present. Temporary Co-chairpersons Ragan and Heddens were elected permanent co-chairpersons by a voice vote. The proposed rules for the Committee were approved by a voice vote. The meeting was adjourned at 2:03 p.m.

II. Iowa Department of Human Services

Overview. Mr. Eugene Gessow, Director, Department of Human Services (DHS), and Ms. Eileen Creager, Bureau Chief, Bureau of Long Term Care, DHS, explained in depth to the Committee how the Medicaid Elderly Waiver Program works, including requirements, services, and limitations.

History. During the 1970s and 1980s there was a growing demand from the elderly and persons with disabilities to stay in their communities, rather than entering institutions to receive long-term care services. However, Medicaid only paid for institutional services. During the 1980s, the federal government amended the Social Security Act under section 1915 to authorize Medicaid to pay for Home and Community-Based Services (HCBS), which is the basis for the elderly waiver. In order to qualify for HCBS, there must be a determination that, but for the provision of such services under HCBS, an individual would require the level of care provided in a hospital, a nursing facility, or intermediate care facility for persons with mental retardation, the cost of which could be reimbursed under the Medicaid state plan. Also, as part of the federal requirements, the HCBS waiver programs must be more cost effective than institutional care, i.e., there must be budget neutrality.

Financial Eligibility. In order to qualify for the HCBS waiver, an individual cannot have a monthly income that exceeds $1,911, which is 300 percent of the social security income limit per month ($637) or approximately 220 percent of the federal poverty level. Additionally, the individual cannot have more than $2,000 in financial resources, must be a U.S. citizen, and must be an Iowa resident.

Under Medicaid, the income of an individual in an institution goes to the provider and the individual retains a personal needs allowance and any amount needed for medical deductions, such as health insurance. Under the HCBS waiver, the individual retains 100 percent of the individual's income in order to pay living expenses in the community. Both individuals must have needs that qualify them to require an institutional level of care.

Level of Care Eligibility Requirements. Eligibility requirements for each HCBS waiver include a medical component which is a determination of the need for an institutional level of care specific to the type of waiver. For example, for HCBS waivers that require an individual to meet the nursing facility level of care, the individual must need assistance with at least one activity of daily living (ADL), such as dressing or personal hygiene. The level of care evaluation is completed by a medical professional, usually the individual's doctor, and the final level of care determination is made by the Iowa Medicaid Enterprise.

HCBS Waiver Services Programs. Once the determination is made that an individual meets financial and medical eligibility requirements, the individual may seek HCBS waiver services. With HCBS waiver services, an individual is also eligible for traditional entitlement Medicaid services, such as medical and pharmaceutical services. An individual must have needs that can be met by the HCBS waiver services and the cost of such services must remain within the HCBS waiver services cap. The individual remains responsible for room and board costs since Medicaid does not pay for these. Services are based on individual needs and not all individuals require the same level of support. The services provided under each type of waiver vary based on the needs identified by the target population. The Iowa HCBS elderly waiver offers 16 services. Each HCBS waiver requires a case manager to assist with service coordination. As of November 1, 2008, 3,280 individuals were on a waiting list for one of Iowa's HCBS waivers. Places on the waiting list are determined on a first-come, first-served basis.

Waiver Compliance — Financial. HCBS waiver services must meet federal cost neutrality requirements, which compare institutional Medicaid costs to HCBS waiver services program costs. The cost neutrality formula requires that the amount the state spends on a waiver services program and regular Medicaid program costs be less than the comparable institutional costs. To meet cost neutrality, each HCBS waiver is assigned a funding cap. The HCBS waiver program budget is determined by the average cost per HCBS waiver services recipient. The assumption is that not all individuals requiring HCBS waiver services will require the same amount of services. HCBS waiver funding and annual enrollments are based on state appropriations for the nonfederal share. HCBS waivers are not entitlement programs—individuals are assessed based on needs, not wants. For the HCBS elderly waiver services program, the cost cap per individual per month is $1,117. The federal share is approximately 63 percent while the state share is 37 percent.

The mental retardation waiver is the most expensive. The elderly waiver is usually the least expensive. The AIDS waiver, which is also the smallest waiver in number of participants, has come close to reaching the cost neutrality limitations due to the cost of medications. The individual funding cap may be increased due to extenuating circumstances, which may be addressed through an exception to policy. For example, an individual may need more intensive nursing services for one or more months or may need a vehicle modification or a home modification that increases costs for a limited period of time.

Case Management. A case manager is assigned to each individual receiving an HCBS waiver. The consumer may choose the case manager, but the number of available providers in the community may be limited. Case managers must meet certain criteria under rules and regulations and must visit individuals at least quarterly. The case manager is a key player for every individual who is on an HCBS waiver. The case managers are allowed to bill monthly.

The Center for Medicare and Medicaid Services (CMS) has developed new quality assurance requirements to ensure the health, safety, and welfare of participants in the elderly waiver. A major and minor incident program is required under all of the waiver services programs including the elderly waiver. The department will now record the deaths of anyone participating in HCBS waiver programs in order to identify any patterns or anomalies.

Discussion. The Committee asked whether there is a massive amount of paperwork and about the digestion of the information associated with such paperwork. Mr. Gessow told the Committee

that DHS is looking at electronic means to receive and digest this information. However, Mr. Gessow stressed that the department needs this information because the elderly are vulnerable members of the community.

The Committee asked about whether money is being diverted from the delivery of waiver services in order to update data systems. Mr. Gessow explained that individuals who participate in the waiver program take an inherent risk in staying in the community instead of residing in a facility with 24-hour care. There is a cost to increasing the level of safety and security provided through waivers and if there is an incident it needs to be reported. Participants, their families, and the community expect reasonable efforts to be made in keeping people safe in their environment. There are different risks associated with a person residing in the institution as opposed to the person residing in the person's own home.

Mr. Gessow explained that the purpose of the documentation in the waiver program is foremost to assure that the individual is receiving good, stable care, followed by the needs of the federal and state governments. The individual's file exists primarily to appropriately meet the needs of the individual. The rate paid to providers, which includes providing documentation, is revisited annually in appropriations legislation. CMS requires certain documentation for participation in and receipt of federal funding under the Medicaid program.

Mr. Gessow emphasized that it is within the purview of the General Assembly to determine the future of waivers. The department makes recommendations, but it is up to the General Assembly to decide the appropriate path.

III. Iowa Alliance in Home Care

Mr. Mark Wheeler, Executive Director, Iowa Alliance in Home Care; Ms. Elizabeth Sutter, Iowa Health Home Care; and Mr. Andy Bagchi, Iowa Home Care, provided the Committee with an overview of issues and recommendations relating to home health from a provider's perspective relating to the elderly waiver program:

Issues. The group's presentation identified nine issues of concern in Iowa's HCBS elderly waiver program.

- Low reimbursement rates. Reimbursement rates are lower than providers' costs. An annual inflation adjustment was suggested to compensate.
- Revised "service" definition. A broader definition of service is needed in order to include the time spent traveling to a patient's home.
- Nursing services coverage. Hourly nursing services are not currently covered by the program.
- Waiting list service delays. In some areas of the state, long waiting lists cause delays in providing services to individuals, increasing the individuals' risks for nursing home placement.

- Excessive regulatory requirements. These requirements add to the costs of providing services and are not reimbursable. One of the new nonreimbursable requirements is the Quality Assurance Program.
- Direct care worker shortage.
- Care management/professional assessment disconnect. Recent changes to the case management program coupled with nonprofessional/non-nursing personnel performing assessments means that there are potentially many individuals being missed who could be receiving services.
- Emergency response system.
- Home telemonitoring reimbursement. There is no reimbursement for telemonitoring services. This technology helps extend limited provider resources and offers significant cost savings for the HCBS waiver program over the long term.

Recommendations. The group's presentation included the following 11 recommendations:

- Increase provider rates.
- Increase funding to reduce waiting lists.
- Streamline the Quality Assurance Program. Requirements should be specific to the type of provider. Inpatient facility rules do not fit home care patients, but home care providers are required to complete this form.
- Home telemonitoring coverage. Reimbursement for telemonitoring services for patient self-management will lower the need for more hospitalizations.
- Revamp direct care worker requirements.
- Bill procedure policy change. Providers should be allowed to bill for each encounter in whole units rather than accumulating the entire month's actual service hours and rounding off to the whole number while filing the claims. Otherwise, cases, especially consumer-directed attendant care (CDAC) cases, become financially unfeasible.
- Include travel time. Drive time to the patient's home should be part of reimbursement since it is part of the service of caring for the patient. An agency spends an average of $10 in travel for each visit.
- Increase public awareness of the HCBS waiver services.
- Include professional assessment.
- Increase use of emergency response systems.

- Increase use of home telemonitoring. This is an economical solution to the nationwide nursing shortage.

Discussion. The Committee asked the group to further explain telemonitoring. Telemonitoring involves a small machine with various attachments specific to the patient to take a certain set of the patient's vital sign readings on a specified basis from the patient's home. The information is transmitted over a phone line to a central monitoring station where a nurse evaluates the information. The cost is $10-$15 per day, not including initial setup. Currently, reimbursement for this service or the equipment is not included as a service covered under the HCBS elderly waiver.

The Committee asked the group to explain why drive time reimbursement is significant. The group told the Committee that in Iowa the average length of drive time to a patient's home, each way, is 22 miles. Currently, providers are not being reimbursed for that time or expense.

The Committee asked the group about the reimbursement of Medicaid versus Medicare. Mr. Wheeler told the Committee that Medicaid pays per visit and Medicare pays based upon an episode of care of 60 days. Medicare rates are currently higher, but under the current reimbursement methodology, in approximately five years, home health providers will be paid less than cost under Medicare.

IV. Department of Elder Affairs

Mr. John McCalley, Director, Department of Elder Affairs (DEA), explained how the department's Case Management Program for the Frail Elderly (CMPFE) coordinates with the HCBS elderly waiver. CMPFE's goal is the same as the elderly waiver services program, which is to allow Iowans to remain independent and in their homes as they age. The CMPFE is funded entirely by state dollars.

The HCBS elderly waiver program offers 16 services while CMPFE offers 32 services. The two programs are dependent on the success of each other. Many waiver clients need services that are not offered through the HCBS waiver, but are provided by CMPFE. Each individual receiving services from CMPFE averages two or three services. If not for CMPFE, these elderly Iowans would be more likely to enter an institution.

Unmet Needs. The CMPFE is an effective investment but there are many unmet needs in the state. More than 54,000 units of unmet needs were reported in the last fiscal year. Reportable unmet needs are those unmet needs known because service is actually provided in the area, albeit underprovided. However, if specific services are not available, there is no way to report needs whether met or unmet.

Discussion. The Committee asked Mr. McCalley to explain the relationship between DEA and the Area Agencies on Aging (AAA). Mr. McCalley said that DEA, through the Commission on Elder Affairs, oversees the AAAs. The AAAs have a large degree of flexibility, but there are "strings" attached through the appropriation and allocation of state and federal funding. The AAAs must develop plans for service delivery which, in turn, must be ratified by the Commission. The members also asked Mr. McCalley to provide a more detailed unmet needs report to the Committee.

V. Iowa Association of Area Agencies on Aging

Ms. Donna Harvey, President, Iowa Association of Area Agencies on Aging, known as "i4a", shared the AAA's role in providing case management to individuals using HCBS elderly waiver services. Ms. Harvey reiterated Mr. McCalley's point that unmet needs are growing and constantly evolving among Iowa's elderly.

Ms. Harvey reminded the Committee that every individual who qualifies for HCBS elderly waiver services is also nursing home eligible. The number of ADLs for nursing home eligibility is the same for waiver services eligibility. The individual's physician has to write a letter addressing the individual's eligibility. DHS evaluates the individual's financial situation and makes the final decision regarding eligibility. The AAAs work with DHS regarding the HCBS elderly waiver services, and with DEA regarding CMPFE.

Case managers have strict education and training requirements including dependent adult abuse prevention training. Informal support caregivers are also written into an individual's care plan. These caregivers include family members, friends, and neighbors.

Ms. Harvey stated that there are concerns about gaps in the HCBS elderly waiver, but that AAAs and the departments are working through these concerns. New reporting forms provide a good system of checks and balances to ensure that clients are safe in their homes. However, Ms. Harvey noted that the final decision always rests with the client regarding whether to go into a nursing facility.

With regard to the Community Directed Attendant Care (CDAC) program, Ms. Harvey noted that the program is wonderful when it works, but the new reporting forms will be helpful in addressing instances in which poor care is provided.

VI. Visiting Nurse Services

Ms. Mary O'Brien, Visiting Nurse Services (VNS), described case management needs through the HCBS elderly waiver services program.

VNS began accepting clients using the HCBS elderly waiver in December 2006. VNS's service area includes Polk and surrounding counties and serves 160 elderly waiver clients. VNS has more than 200 employees, including social workers, translators, outreach workers, nurses, and transportation workers. In order to support the organization, VNS has branched out and sought and received grants in many areas, including child care.

Over 59 percent of VNS's HCBS elderly waiver clients are non-English speaking and the largest group of those are Vietnamese (86 percent). Most of these clients are very fragile, appear older than they are, have mental health problems, are isolated, have a history of neglected health needs, and have a long and strenuous work history. The difficulty of communication and language barrier may lead to a lack of access to medical care services for years.

The greatest needs of VNS clients are interpretation services, CDAC services, emergency response devices, and assistive devices. The monthly cost per client for case management is $79.64, but reimbursement is only $70.

Discussion. The Committee asked about the high incidence of non-English speaking frail elderly, particularly the high rate of Vietnamese elderly. Ms. Diana Burkert, a VNS case manager, told the Committee that the succeeding generations following the arrival of the original refugees have been successful, but they are struggling just as any younger generation to take care of their parents and grandparents. The original refugees who arrived 20 or more years ago did not speak English, many never fully assimilated, and many may never have received medical care. Now these individuals are too proud or refuse to seek out care. This puts a strain on the families who are attempting to care for the individuals without pay. In these cases, VNS can make an enormous difference.

Ms. Burkert shared one example. An elderly Asian woman was immobile from pain and isolated in a bedroom when VNS first saw her. Her daughter was unable to work because she was staying home to care for her mother. Once a VNS case manager was able to evaluate the mother and provide medical care including dentures, hearing aids, and blood pressure medications, the mother was able to care for herself, and her daughter returned to work full-time. This individual is now assisting with child care and is interacting with her family. Her quality of life and the quality of life of her family is much improved.

The Committee asked about the need for and cost of interpretation services. Ms. O'Brien said that for VNS elderly waiver case management, interpretation is the number one necessity and interpretation costs are very high.

VII. Iowa Association of Homes and Services for the Aging

Ms. Dana Petrowsky, President and CEO, Iowa Association of Homes and Services for the Aging, presented recommendations to increase funding for and the cap under the HCBS elderly waiver, including but not limited to assisted living and adult day programs. The recommendation includes the methodology to provide for these increases.

The most commonly used service by individuals in an assisted living program using the elderly waiver is CDAC services. CDAC services are service activities performed by a person to help the recipient of services with self-care tasks that the individual would typically do independently if the individual were otherwise able.

With the option of home care, there are fewer individuals in nursing facilities who don't need to be, but this also results in increased demand for services for individuals who need assistance at home.

The Committee was asked to check the status of House File 617, which was a bill enacted in 2005 directing the DHS to request a Medicaid waiver to add assisted living services to the HCBS elderly waiver.

VIII. Iowa Health Care Association (IHCA) and Iowa Center for Assisted Living (ICAL)

Ms. Cindy Baddeloo, IHCA Deputy Director and ICAL Director; Ms. Jeanine Chartier, Char-Mac Assisted Living, Holstein/Lawton; Ms. Suzanne Menke, Kensington/Fort Madison; and Ms. Stacy Hejda, Assisted Living Partners, Cedar Rapids, discussed the HCBS elderly waiver program relative to assisted living programs.

Based on a 2006 survey, Ms. Baddeloo reported that there are more than 235 assisted living programs in Iowa. These are community residential facilities that are paid for primarily through private resources. The average age of a resident is 87 and the majority of residents are female. More than 65 percent of residents have no dementia. The most common needs are independent services needs such as medication management, housekeeping, traveling, and laundry. The most common medical issues are arthritis, depression, and hypertension.

Ms. Baddeloo also asked the Committee to investigate the status of House File 617. Ms. Baddeloo noted that there are only 186 assisted living providers and 550 tenants participating in the Medicaid elderly waiver.

Ms. Baddeloo reviewed the assisted living waiver program rates of other states.

Ms. Chartier emphasized the desolate outlook for the elderly in rural Iowa. She works with CDAC services, but reimbursement is so low that her assisted living program cannot make a profit. She involves the community to support her tenants because without her services the clients would have to go to nursing homes. Ms. Chartier's clients' average income is $650-$750 a month. Ms. Chartier reported that she cannot provide necessary services for less than $1,000 a month for most of the clients. These tenants want to stay in their hometowns and want to be cared for by those in their towns.

Ms. Menke, a social worker, stressed the burden extra paperwork and documentation has put on providers. The new hoops of paperwork, which may require more employees, and the lack of reimbursement scare providers. The lack of consistency about documentation requirements between agencies is confusing and costly. Ms. Menke's program is no longer accepting individuals using HCBS elderly waiver services. In order to accept new people using waiver services, the new Quality Assurance Program would need to be eliminated. The requirements were written for a different waiver program and include sections such as child abuse guidelines that are not applicable to assisted living programs.

Ms. Hejda explained that the trigger for assisted living is most often the individual's family and the individual's physician or the case manager who is assisting someone already using elderly waiver services in their home. The biggest issue involved with assisted living is safety. Assisted living is a social model, but assisted living programs vary. Each facility falls under many state agency regulations, rules, and policies. Ms. Hejda said that the new regulatory documentation is going to cause what began as a social model to become a regulatory nightmare. Many of the services provided by assisted living programs are not reimbursable by Medicaid, so these programs are truly restricted by the $1,117 elderly waiver services cap.

Ms. Baddeloo asked the Committee to consider recommending an increase in the elderly waiver rate to 60 percent of the average nursing facility daily rate.

Mr. Gessow addressed the concerns about paperwork and documentation. Mr. Gessow stated that the waiver programs are regulated through and audited by CMS, including quality assurance requirements. A form for self-assessment is one of the least intrusive ways DHS has developed to comply. DHS does not have enough inspectors to do on-site inspections. In order to qualify for the federal waiver program, the state needs to establish a way to document quality. As for the CDAC form, Mr. Gessow noted that these providers are not used to the documentation standards required in a hospital or institutional setting, so the state is more vulnerable to audits and repayment if adequate documentation is not provided. DHS has tried to create a form that would help providers who are not used to providing documentation do just that and reduce the state's risk of losing funding.

Ms. Hejda agreed that a provider must provide an adequate record of services provided to be eligible for payment. However, she expressed concerns about interpretation of the documentation. There is real concern that a provider who documents a service believed to be performed correctly will later be penalized if the services are determined to be ineligible for payment. For employers, the biggest concern is employees. Employee wages are going up and yet reimbursements are not increasing, and employers are having a hard time attracting and keeping good employees.

Mr. Gessow suggested it is best to have consistency between providers and the best way to ensure this is to reduce layers of bureaucracy.

Discussion. A member of the Committee suggested reviewing provisions of a higher reimbursement rate for assisted living, especially given the current economic downturn which greatly affects those close to retirement.

IX. Final Report

The Committee concurred that a final report including the documents and information presented during the meeting as well as any follow-up information submitted should be compiled and forwarded to the Joint Appropriations Subcommittee on Health and Human Services for further review.

X. Materials Filed With the Legislative Services Agency

The following materials listed were distributed at or in connection with the meeting and are filed with the Legislative Services Agency. The materials may be accessed from the <Additional Information> link on the Committee's Internet web page:

http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=241

1. Committee Proposed Rules.
2. Presentation by the Department of Human Services, November 13, 2008.

3. Medicaid Home and Community-based Services Waiver Overview, Department of Human Services, November 13, 2008.
4. Home and Community-based Services Elderly Waiver Information Packet, submitted by Department of Human Service, November 13, 2008.
5. Iowa Medicaid Elderly Waiver Program Home Health Issues & Recommendations, Iowa Alliance in Home Care.
6. Case Management Program for the Frail Elderly, Department of Elder Affairs, November 13, 2008.
7. Case Management Program for the Frail Elderly, Fiscal Fact Sheet, Department of Elder Affairs, November 13, 2008.
8. Department of Elder Affairs Service Categories Compared to Elderly Waiver Service Array, November 13, 2008.
9. Comments, Iowa Association of Area Agencies on Aging, November 13, 2008.
10. Elderly Waiver Case Management, Visiting Nurse Services, November 13, 2008.
11. Fair Funding for Alternative Services/Explanation of Fiscal Impact for New System, Iowa Association of Homes and Services for the Aging, November 13, 2008.
12. Assisted Living Survey 2006, Iowa Center for Assisted Living, November 13, 2008.
13. Recommendations, Iowa Center for Assisted Living, November 13, 2008.

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