Presentation by the Department of Human Services

Medicaid Elderly Waiver Interim Study Committee

What are HCBS Waivers?

- In the 1970s there was a shift -- both in demand and recognition – that people could be served in their homes.
- Until early 1980's Medicaid only covered institutional services (nursing homes, hospitals and ICF/MRs) because that was the main way people received long-term care services.
- The Social Security Act was amended to authorize Medicaid to pay for Home and Community Based Waivers – Section 1915©.

1915 (c)(1) authorizes:

- Medicaid payment for home or community-based services (other than room and board), under a waiver approved by CMS.
- The HCBS services must be provided pursuant to a written plan of care
- If there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.
- HCBS waiver programs must be more cost effective than institutional care. The law lays out the 'budget neutrality' calculations.

HCBS Waivers vs. State Plan

Under a waiver states can:

- Cap enrollees, and have a waiting list (under an approved methodology)
- Cap costs (in fact states must assure budget neutrality)
- Target the population that will be served
- Choose the services that will be covered to meet the needs of the target population from a CMS menu.

HCBS Waiver Compliance

States must assure and provide oversight over the following:

- Administrative Authority of the Single State Medicaid Agency
- Participant Access and Eligibility – Medicaid and Level of Care
- Participant Services – Received by Qualified Providers
- Participant-Centered Plan and Service Delivery – System for Service Plan Development, Risk Assessment and Mitigation, Monitoring
- Participant Direction of Services - Self Direction
- Participant Rights – Fair Hearing, Dispute Resolution, Grievance/Complaint System
- Participant Safeguards – Reporting and investigation of major and minor incidents, Safeguards with restraints and restrictive interventions
- Systems Improvement – Discovery, remediation and improvement regarding the HCBS waiver system
- Financial Accountability – State oversight of cost neutrality, financial audits, payment process oversight, State oversight of CMS requirements regarding client participation/co-pay/restrictions of payments (i.e. Room and board)

New CMS Quality Assurance Requirements

- In response to a letter from Senator Grassley and Senator Breaux in July of 2003 pertaining to the lack of oversight and monitoring of HCBS waiver programs, CMS developed a Quality Action Plan.

- The HCBS Quality Framework is the Quality Action Plan and is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports for people with disabilities. The Framework focuses attention on the desired outcomes of HCBS quality management and improvement efforts.
  - **Design:** Designing quality assurance and improvement strategies into the HCBS program at the initiation of the program

- **Discovery:** Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- **Remedy:** Taking actions to remedy specific problems or concerns that arise
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that assure continuous improvement in the HCBS program.

HCBS Eligibility – Medical and Financial

- Must meet Institutional Level of care – same for NF & ICF/MR as for HCBS waivers (a MEDICAL component)
- Financial Component – The income limits for long-term care (institutional and waiver) are **higher** than for **non**-long term care programs:
  - 300% of the SSI limit, which is approximately $1911 or 220% of the FPL
  - In comparison, eligibility for Medicaid parents is about 28% of FPL, eligibility for elderly and disabled who do not meet level of care is about 75% of FPL (both calculations dependent on household size and accountable net income)

Iowa's HCBS Waivers

- HCBS Waiver Target Populations: AIDS/HIV, Brain Injury, Children's Mental Health, Elderly, Ill and Handicapped, Mental Retardation and Physical Disability
- The State General Fund pays for the state match (about 38%) for all but the Adult MR Waiver, for which the counties pay the state match.
- All 7 waivers have enrollment caps, but the Elderly waiver cap is high enough that we have never had a waiting list (and also state budget policy)
- Waivers grow at approximately 9% per year
- All others either have waiting lists, or have had small waiting lists at some time
- The average enrollment has increased by 10.46% in SFY 2007 and 9.93% in SFY 2008

Waiver	Monthly individual cost cap	Enrollment Cap set by budget	Number of individuals approved	Number of individuals in process	Number on Wait List as of 11/1/08
AIDS/HIV	$1717	56	49	3	0
Brain Injury	$2812	1168	1077	93	534
Children's Mental Health	$1873	1117	690	172	252
Elderly	NF $1117 SNF $2631	12052	9525	N/A	0
Ill and Handicapped	NF $904 SNF $2631 ICF/MR $3203	3163	2411	576	1409
Mental Retardation	No cap	12110	10496	371 (Children/state cases)	State Cases 78 Children 0
Physical Disability	$659	1292	797	346	1009

Services & Cost Limits

- The waivers differ by which type of level of care is applied (Hospital, NF and/or ICF/MR level of care)
- They each have different caps on the amount of HCBS services allowed each month:

- Cost caps are applied at the individual member level (not the program as a whole) in dollar amounts (i.e. $1117 per person per month).
- The caps ensure the HCBS programs remain budget neutral.
- The cap only applies to the HCBS services. Those on the waivers are entitled to all other Medicaid services (hospital, physician, prescriptions, etc.), which are over and above the caps. The "State Plan" services (non-waiver) must be utilized to the fullest extent before waiver services are used.

- The differences in services and caps are partly due to differences in the needs of the target populations, but more due to budget constraints at the time each waiver was authorized in statute.
- It has been noted by many, including DHS, that it would be beneficial to have more consistency across the 7 waivers in both services offered, and in the monthly caps. This has not happened largely due to budget constraints.
- The HCBS waiver expenditures has increased by 8.31% in SFY 2007 and 12.74% in SFY 2008

WAIVERS - SFY 2008

	TOTAL DOLLARS	FEDERAL SHARE	STATE SHARE	COUNTY SHARE	TOTALS CHECK	AVG COST PER PERSON PER MONTH
MR:	$ 285,112,117	$ 176,111,317	$ 17,481,827	$ 91,518,974	$285,112,117	$2556.00
ELDERLY:	$ 64,661,760	$ 39,940,311	$ 24,721,450	$ -	$ 64,661,760	$592.85
ILL & HANDICAPPED:	$ 19,666,443	$ 12,148,514	$ 7,517,929	$ -	$ 19,666,443	$829.25
AIDS:	$ 496,759	$ 306,841	$ 189,918	$ -	$ 496,759	$944.41

BRAIN INJURY:	$ 17,631,128	$ 10,889,864	$ 6,741,264	$ -	$ 17,631,128	$1531.94
PHYSICAL DISABILITY:	$ 3,666,015	$ 2,264,375	$ 1,401,640	$ -	$ 3,666,015	$531.77
CHILDREN MENTAL HEALTH	$ 4,362,374	$ 2,693,920	$ 1,668,454	$ -	$ 4,362,374	$946.90
	$ 395,596,596	$ 244,355,142	$ 59,722,481	$ 91,518,974	$395,596,596	

The handouts include a matrix of the services and other specifics for each waiver.

Elderly Waiver

- NF Level of Care (Daily assistance with Activities of Daily Living's-dressing or personal hygiene)
- Plan of care developed by an Elderly Waiver Case Manager, which includes Area Agencies on Aging, Iowa Department of Public Health, Targeted Case Management and Agencies certified by CARF or the Council on Accreditation.
- Services must be approved by the case manager
- Services covered: Adult Day Care, Assistive Devices, Consumer Directed Attendant Care - individual, agency, assisted living facility (CDAC), Chore, Home Delivered Meals, Home Health Aide, Homemaker, Home & Vehicle Modification, Mental Health Outreach, Nursing, Nutritional counseling; Personal Emergency Response, Respite, Senior Companion, Transportation. Supervision in a residential setting is not covered.
- Special note on CDAC – self-directed personal care options. Services include direct assistance with personal hygiene, meal assistance, wound care, cognitive assistance, communication, transportation, specific skilled services related to a health condition (listed in Informational packet).
- Special note on Assisted Living:
  - Nationally, CMS is questioning the viability of Assisted Living in the HCBS waiver programs, as it is a bundled service that includes room and board. HCBS will only pay for services, not room and board costs.
  - HF 617 directed DHS to request a waiver to add assisted living services to the HCBS Elderly waiver program. State representatives including DHS and industry staff met and developed a proposal to amend the Elderly waiver to include

assisted living in a three-tiered payment system. The DHS submitted the request to the Centers for Medicare and Medicaid (CMS). CMS would not approve because a State cannot set a higher cap for a specific service that is higher than the overall monthly cap for the program. A State cannot carve out the Assisted Living Consumers within the Elderly waiver to pay at a higher monthly cap. Therefore, CDAC was developed as a service within the Elderly waiver as it met the requirements from CMS.

Recommendations:

- Services and monthly caps are unequal within HCBS waiver programs. Equalize caps and services among waivers
- Funding to eliminate waiting lists in all waivers
- Assisted Living is difficult to implement with HCBS, as room and board is not included. Change reimbursement unit to actual services/hours provided instead of a monthly fee.
- Increase direct care worker rates to provide a living wage.
- Lack of direct care workers throughout the state-national issue. Increase the direct care worker in Iowa.
- Provide health insurance for providers not associated with an agency.
- Continue to address the lack of documentation-particularly with CDAC but also an issue with some agency providers.