



Collaborative Work Group on Services for Adults with Developmental Disabilities

Monday, February 11, 2013, 9:00 am – 4:00 pm

West Conference Room

Joe R. Williams, 700 West State St, Boise, Idaho 83702

Collaborative Work Group's Vision:

By 2016, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms, and rights as their neighbors. They have access to a sustainable service system that provides quality, individualized supports to meet their lifelong and changing needs, interests and choices.

Meeting Purpose:

- Review Legislative Report
- Hear report from the Employment First Consortium
- Discuss current system issues; make recommendations
- Discuss where this service system is headed; what are the services that we want to make sure are included and what is the impact of managed care
- Hear about other states' approaches
- Discuss and decide on the use of focus groups

Present: Art Evans, Tom Whittemore, Jean Christensen, Oscar Morgan (FACS), Jim Baugh, Maureen Stokes, Bill Benkula, Marilyn Sword, Corey Makizuru, Lisa Cahill, Joanne Anderson, Katherine Hansen, John Chambers, Noll Garcia (with Jason Spjute), Dina Flores-Brewer, Roger Howard, Don Alveshere, Jason Lowry, Lisa Hettinger

DRAFT MINUTES

Marilyn Sword convened the meeting at 9:10 am. She reviewed the meeting ground rules, purpose and agenda. Attendees introduced themselves.

The notes from the December 12, 2012 meeting were distributed and reviewed. There was consensus that the notes accurately reflected the meeting content.

Legislative Report and Disability Advocacy Day - The report to the legislature was distributed and reviewed. Marilyn said that she had presented this to the Senate Health and Welfare Committee on February 7. Also in attendance from the CWG were Katherine Hansen, Art Evans, Roger Howard, and Maureen Stokes. The presentation was well received and Sen. Heider read the Vision Statement to the committee. Following this report, Katherine invited the committee to Disability Advocacy Day activities on the capitol 4th floor on Friday, Feb. 8.

On February 8 from 8-10 am, the two Health and Welfare Committee held a joint "listening session" in the capitol auditorium. Some of the CWG members were able to attend and shared their observations from that day. Most of those testifying spoke about restoring preventative dental services and improving mental health care in Idaho. Other topics mentioned were children's services redesign, transportation, Medicaid expansion, assisted living and certified family home payments. Senator Lodge sent one person's testimony to Art Evans for a response. It was unfortunate that Senators Lodge, Nuxoll, and Bock were not able to attend and that Chairman Wood was only able to attend for a short period.

To follow up, it was recommended that Marilyn **send out the CID Legislative Tool Kit to all CWG members** so they could use it to help educate their legislators, particularly new ones, about our issues. **Katherine will provide a list of the legislators (about 20) who visited the 4th floor CID displays** on Disability Advocacy Day so CWG members can follow up. It was requested that **when CWG members contact their legislators to please let others know about the issues discussed and responses received**. If members will send that to Marilyn, she will distribute to the group. Katherine also **suggested that the Office of Performance Evaluations (OPE) conduct a study on the impact of HB260, particularly on Children's Benefit Redesign and Mental Health (Behavioral Health) Managed Care OR ask the Senate and House Health and Welfare committees to convene a work group to look at these issues**. It was noted that any studies taken on by OPE must be recommended by the Joint Legislative Oversight Committee (JLOC).

Employment First Consortium (IEFC) - Tracy Warren provided an update on the work of this group. The group met in January and received a draft of the Phase 1

report from the Institute on Community Inclusion (ICI). These consultants are looking at system models and ways of funding employment supports in Arizona, Connecticut, Wisconsin, Oklahoma, Montana, and Oregon in addition to Idaho. The report was distributed and **will be sent out to all CWG members**. It provides some basic statistics from the states reviewed compared to Idaho data. It looks at system structures and the use of work incentives. For the purposes of comparison, data cited in the report come from the National Core Indicators project if states are participating. Idaho is not. The intent is that Idaho may be able to take information learned from other state's models. The Phase 2 report which will be delivered by ICI later this spring, will include information on employment outcomes, quality assurance data and model barriers.

The group's next meeting is Feb. 28 in Boise. John Butterworth and Jean Winsor from ICI will be coming to present information in person. They are also working with a group of states that make up the State Employment Leadership Network or SELN. ICI is examining what practices are used in high performing states. One example is that in Idaho, about 1% of community supported employment is paid for by Medicaid vs about 10-11% in other states around Idaho. They are also gathering information about natural supports in the workplace.

A subcommittee of the IEFEC is working on public awareness materials. They will share information about the project at the Tools for Life conference in Boise on March 7-8 and the statewide Self Advocacy conference in Boise on May 21-23. The Tools for Life conference also includes a feature called Its My Business Expo at the Riverside Hotel on March 7. It will include various displays by business entrepreneurs with disabilities and is free to the public. The public awareness group is working on their message to policymakers, identifying supportive groups, and gathering stories of employment successes. The IEFEC is also looking to establish an Employer Advisory Group and a Self Advocates Advisory Group. A tool kit will be developed for Consortium members to use to train others and present to groups in their communities. **Katherine suggested that a letter of invitation be developed that solicited organizations to endorse Employment First**. ACCESS has already endorsed. Tracy and Noll Garcia are working on strategies for self advocate involvement.

CWG members expressed interest in having comparison data regarding such information as number of hours worked compared to support hours, wages, "milestone payments" (which some states are starting to use). Maureen asked what data sources

ICI is using and if they are interviewing people. Tracy indicated that they would be talking with individuals as part of their information gathering.

Current System Issues –

1. Access to PsychoSocial Rehabilitation (PSR) & Developmental Therapy for people with Dual Diagnosis

When this was reauthorized to begin being offered effective 7/1/2012, the estimates were that there were 600 people with dual diagnosis about 75% of whom (450) would use both services. To date, only 70 have applied and all but 1-2 have been approved. The major concern is that the cost of PSR must come out of the person's DD budget and that the cost of that service is much greater than DD services. This makes it a disincentive for people to access PSR. In fact, with only one question on the assessment about mental health needs, the most a person could qualify for would be 1.5 hours of PSR. Prior to HB 260, passed in 2011, PSR came out of the DD budgets of individuals and that process has not changed. What has changed is that people have decreased budgets making it more difficult to afford the more expensive service. The budget decreases have been the result of a new iteration of the budget tool that changes the accuracy of correlation from $\pm 5\%$ to $\pm 25\%$. Also with legislative changes over the last couple of years, the "exception review" for budgets is now available only for people with high or intense levels and reconsideration through administrative appeal can only be based on issues of "health and safety". With the implementation of managed care for behavioral health slated to begin July 1, 2013, this issue will be altered since PSR would be accessed through that system instead of being part of the DD budget. Concerns were expressed that this might result in budget decreases for people with dual diagnosis but Art assured the group that would not occur.

Since the issue of the **budget tool**, what it calculated, and what is needed for complete documentation are all complex and not well understood, Katherine requested that we have a **presentation** on this topic **at our next meeting**. **Marilyn will follow up with Jean and Art on this.**

2. Potential changes to "health and safety" restriction in current law

This has been an issue for some since the law was changed to restrict budget reconsiderations to matters of "health and safety" only. The unintended consequence of this is that, particularly as budgets have been cut, people have

lost employment supports in order to maintain their living supports. The Department has also moved away from exception reviews on budgets (except for those with high or intense needs) and budget reconsiderations are now done through administrative appeal. To remove this “health and safety” restriction would require changing the language in the law but it may be difficult as this issue is now the subject of an active lawsuit. There may be reluctance to change the law until that is settled, but disability advocates will be talking with Health and Welfare committee leaders to see if they would support removing that language in order for people to receive the employment supports they need.

3. Process for approving home modifications

This is an issue that was highlighted in a rule change negotiated last summer. At that time, the original rules denied modifications in rental homes instead requiring them to be owner-occupied homes in order for Medicaid to pay for modifications. Advocates objected to this language, and additional wording was added that now allows these modifications with prior approval by the DHW. These modifications must come out of the person’s budget but are pro-rated across multiple years as appropriate. The rules covering this were before the legislature this year and were approved by the House Health and Welfare committee.

Bill Benkula has been working with a family in Twin Falls who have been trying for more than a year to get modifications made to a rented home. Medicaid requires there to be at least two bids from Molina approved vendors and a letter from the homeowner stating their approval for these changes. Medicaid also looks at this from the perspective of whether it is a long-term improvement and if alternatives have been considered. An example of this is the purchase of a Hoyer lift that could be used throughout the home instead of modifying a bathroom. Problems with this process occur when people do not understand the steps they must follow and when there are no Molina vendors available in a particular area. It was suggested that people should be directed to the Department’s care managers if they have questions about this and that local companies be encouraged to become Medicaid vendors.

Members suggested that in the future, the CWG look at the issue of housing for people with disabilities.

4. Efforts to restore cuts in services (Dental, Vision, Podiatry, Chiropractic)

A number of cuts were made in services to people with disabilities through HB 260 in the 2011 legislature. Preventative dental services were eliminated for adults but in 2012, HB609 restored those for people on the DD and A&D waivers. Advocates are working to see if that can be expanded to all adults on the Medicaid Enhanced Benefit Plan. This has an estimated fiscal impact of \$1.2 million in state funds. There was discussion of how to gather data on the cost of not restoring that benefit such as cost of ER visits, hospitalizations, etc. to compare with that fiscal note. The Hospital Association may have some of those numbers. Tom Whittemore shared that ICFs have to provide that restorative care as part of their content of care. One of the issues that needs to be looked at over the long term is the issue of people with disabilities who need sedation, even for preventative care, and the fact that many dentists cannot or do not provide that.

System Shift Discussion - As Idaho moves from a fee-for-service system to an outcome-based, value-based one, what does this mean and what is the timeline for these changes? What services do we need to ensure are part of the system?

Managed care is coming. Although there is nothing definitive except for the existing transportation brokerage and dental program and the pending Behavioral Health and Dual Eligible models, it is generally accepted that the system is shifting in that direction for all people, including people with developmental disabilities. Part of this is because “fee-for-service” has been targeted as the “problem” but managed care does not mean that there are no fees. Managed care networks will still have to pay fees to the providers in their networks. It is just that those fees will have to fit within the per member/per month reimbursement that the managed care organization gets for coordinating and providing the required services to the defined population.

There was lengthy discussion regarding the values and outcomes that the CWG members would like to see. What would that look like operationally? What type of services would be included – both medical care and long term services and supports. Quality assurance would be even more important; how would that be structured? What would be the best vehicle for providing managed long term supports to people with developmental disabilities? In Virginia (and also in Arizona), the state is the managed care organization. Corey mentioned that there are currently 37 states that are

requiring coverage of children with autism up age 15. The per child cost cap is \$32,000 annually.

At the end of the discussion, group members asked that Paul Leary be invited to attend the next CWG meeting to provide his vision for future services and his definition of valued-based and outcome-based, terms used in a presentation he provided to a legislative committee earlier in the current session.

Access to services/provider rates/cost study

HCBS/DD service providers are concerned about lack of access to services in some parts of the state and the lack of rate increases in recent years. Changes in law and rules link those two issues to provider rate/cost studies that would be conducted by DHW and which would require 100% provider participation. The results of those surveys would be the basis for rate and system changes. The last survey was done in 2009 (?) and rates were not increased as a result, due primarily to lack of funding. Providers are now wanting to know what would have to occur to trigger another rate survey, what constitutes lack of access, and how the Department is establishing its baseline data.

Lisa Hettinger from Medicaid joined the meeting to explain what the Department is doing. In developing their baseline, the Department is looking at current services, rates for those services, the number of providers, the number of recipients (or people needing services). Lack of access to services could drive a rate study but how is that lack of access determined? What does access or not having access mean? Indicators might include the number of critical incidents filed or complaints received from both providers and recipients. The problem is how is unmet need determined. How is this measured? Would someone call Medicaid if they are told that a service is not available or would they just assume that was something they would have to live with? Determining the need vs. the supply would be labor intensive to gather but valuable information. Maureen stated that in Oregon, they are also looking at staff turnover and average wages as data points in their baseline. Lisa indicated that the Department would welcome input from the CWG on this. Other comments included:

- For certified family homes, surveying a provider group or association won't work because they do not have one; reimbursement has gone down; recipients don't complain and providers just do less

- The system is in a constant state of adapting to changing services and increasing costs
- Adequate access cannot be assumed from a claims-based baseline (number of provider agreements, number of claims filed, etc)
- Geography needs to be part of the consideration
- Providers need to be educated on how to accurately report data so that it is meaningful and consistent; just requiring 100% participation does not guarantee that

A committee was designated to work on these issue and provide feedback to the Department. The group will look at the rules (16.0310.1201), costs, adequacy of access and provider incentives. The committee is composed of Katherine Hansen, Maureen Stokes, Jim Baugh, Tom Whittemore, Bill Benkula, Jason Lowry.

Update on managed care models in progress

- Behavioral Health Managed Care

The proposals in response to the Request for Proposals are in and are being scored. A contract has not yet been signed but July 1, 2013 is still the target date for implementation. There were two questions from the group:

- Would school-based PSR be included in this contract since it includes both adults and children?
- Would the contractor lose money (per member/per month payment) if a person went into a psychiatric hospital?

It was suggested that Pat Martell or Paige Grooms would know the answers and might be invited to attend a CWG meeting to provide an update.

- Dual Eligible Managed Care

The application to CMS is still in negotiation and is still expected to go live January 1, 2014. The application is available on line at <http://healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/Proposal%20Submission%20to%20CMS.pdf>. This is the original application submitted in May, 2012. Updates to that application can be found at:

[http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCareManagedCar e/tabid/1910/Default.aspx](http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCareManagedCare/tabid/1910/Default.aspx).

All DD or A&D waiver services for eligible individuals will be part of this contract. This will be a 3 way partnership between the federal government, the state, and

the managed care organization(s). In Idaho, over 1,200 people with developmental disabilities (out of 3,500 people with DD who are on Medicaid) are also on Medicare. Enrollment in this managed care will be mandatory, there will be at least 2 managed care organizations (MCOs), payment to the MCOs will be a per member/per month (PM/PM) amount. Providers can belong to multiple networks but the MCOs do not have to include any willing provider. People will be able to opt out of the Medicare part but not the Medicaid part.

Research from other states:

Florida (Marilyn Sword) In the state of Florida, they implemented managed care using an 1115 waiver. Initially this was in 2 counties with the expectation that it would grow to five counties. Long term services and supports and institutional services were to be added in years 3-4 (out of the waiver's 5 years) but that has never happened. Marilyn distributed a summary of Florida plus some supplemental information on Arizona and Michigan since those are two states that Florida is looking at. **(Those will be attached to these notes)**. The Florida DD Council contracted with a consulting firm to work with a stakeholder group to pull together recommendations as well as specifications that a managed care organization would have to meet if it was allowed to include long term services and supports to people with developmental disabilities. **Marilyn will send a copy of those specifications to Art.** It is worth noting that advocates in Florida did not support a commercial MCO because they had no experience coordinating these types of services, they were not transparent in their operations, and no MCOs would take this on. Instead, for this population, advocates support either a state agency serving as the MCO or a provider network or a hybrid of the two. Their research indicated that no state that was covering long term services and supports to people with DD were using a commercial MCO. Instead they were using one of the other options above.

Oregon (Maureen Stokes) In Oregon, stakeholders came together and used a Medicaid systems change grant to develop a system (REBAR) with improved, individualized rates. The system is county-based and uses 1915(i) and 1915(c) authorities. The assessments for eligibility are done at that county level and most people are found waiver-eligible. From there, the person can choose self-direction with a brokerage or traditional services with a case manager. They use the Supports Intensity Scale (SIS) plus supplemental evaluations. There are five assessors for the entire state and they do all the SIS evaluations. This determines the level of care and

budget which is in seven tiers. The focus of the system is community integration and it appears to be very user friendly. It provides information including a website and videos for people to access before they go through the assessment process. The state has worked with providers on rates and factors in living arrangements into those rates. Self-directed brokerage services may be hourly or daily. Maureen has much more information on Oregon that she can share with the group.

Rhode Island (Corey Makizuru) – In January 2009, Rhode Island received approval from CMS to use an 1115 Waiver (Research and Demonstration) to modernize their Medicaid Program. Henceforth, Rhode Island operates its Medicaid Program under two authorities, e.g. (1) State Plan and (2) Rhode Island 1115 Global Consumer Compact Choice Waiver. The exciting part, federal government gave RI authority to receive federal matching funds for services for populations for which federal funds are not traditionally available. It allowed discrete set of services that would delay the need for full Medicaid services to (1) people over 65 with too many resources to qualify for Medicaid and (2) childless adults who have severe behavioral health needs. Here are links to more information, including a 24-minute+ video:

http://icvclients.com/nescso/rhodeisland_presentations/global_waiver/

<http://www.eohhs.ri.gov/>

<http://www.dea.ri.gov/>

Corey will continue to research information on Rhode Island and share with the group..

Upcoming Focus Groups

In 2012, CWG members discussed holding focus groups in the spring of 2013 to gather information from providers and consumers across the state. At that time, it was envisioned that these would also be used to share information about system changes. With so many changes in the works, it was decided to have a committee take on this issue and determine if this is the best use of resources at this time and if they would serve the purpose originally envisioned. **Marilyn Sword, Roger Howard and Katherine Hansen will serve on this committee and make recommendations prior to the next meeting.**

Next Meeting: Monday, March 25, 9 am – 4 pm. Location to be determined.

NOTE: Highlighted text indicates action item or follow up needed.