Negotiated Rulemaking Meeting and Comment Summary

May 31, 2012 2PM - 4PM (MDT) 1PM – 3PM (PDT)
Negotiated Rulemaking DOCKET NO. 16-0310-1202
Video meeting with locations in Lewiston, Boise, Twin Falls and Idaho Falls as published in the Administrative Bulletin (See attached attendee lists)

Facilitator: Art Evans, Developmental Disabilities Bureau Chief
Bureau of Long Term Care - Mark Wasserman, Alternative Care Coordinator
Bureau of Developmental Disabilities – Stephanie Perry, Alternative Care Coordinator

Call to Order and Outline meeting format

I. Purpose of Meeting

a. Introduction to Aged and Disabled (A&D) and Developmentally Disabled (DD) waivers
   i. The A&D Waiver assists Idaho's elderly and physically disabled citizens to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. Services can be provided in a participant's home, a certified family home, or in a residential assisted living facility. This waiver provides eligible individuals the ability to receive the care they need in the home or community rather than in an institution (Nursing Facility).
   ii. The DD Waiver assists Idaho's developmentally disabled citizens to maintain and encourage individual choices, avoid unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, and achieve and maintain community integration. Services can be provided in a participant's home or a certified family home. This waiver provides eligible individuals the ability to receive the care they need in the home or community rather than in an institution (Intermediate Care Facility for the Intellectually Disabled).
b. Medicaid's A&D and DD Home and Community Based Services (HCBS) waivers expire on September 30, 2012.
   i. In order for Idaho to maintain waiver authority and offer waiver benefits, a new waiver application for each must be submitted to the Centers for Medicare and Medicaid Services (CMS) prior to July 1, 2012, and be approved by CMS prior to October 1, 2012.
   ii. Prior to submission, the Department is seeking public input on changes to rules for the A&D and DD HCBS waivers to be made in conjunction with the renewal of these waivers.
   iii. Medicaid wishes to align the waiver rules and make them as consistent as possible, given the different natures of the populations.

II. Discussion Points

a. Removal of behavioral consultation and psychiatric consultation on the A&D Waiver only. The DD waiver does not have psychiatric consultation and will keep behavioral consultation as a service.
   i. These services have been not been billed since the 10/1/2008 waiver year began.
b. Waiver service definition changes.
c. Provider qualification changes.
d. DD Skill Building and Active Treatment.

III. Follow Up

a. Written comments for Docket No. 16-0310-1202, are to be submitted on or before June 8, 2012 to:

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Negotiated Rulemaking - Comment Summary
DOCKET NO. 16-0310-1202

Comments from 5-31-12, Written Comments Submitted Post-Meeting, and Responses
Verbal and written comments were submitted by the following individuals/organizations: Chris Johnson, Marilyn Sword, Kelly Keele, Wendy Cox, Amy Taylor, Lisa Cox, Scott Burpee, Kathleen Mathews, Disability Rights of Idaho

Comments	Responses
Adult Companion Services	
Adult Companion Services has a reimbursement rate that is too low. Providers have not had a raise since 2000. Services included in the Homemaker definition are also included in the adult companion definition, but homemaker services are paid at a higher rate. Consider changing the rules to get rid of the duplication of adult companion and homemaker services.	Companion Services and Homemaker Services are two distinct services on the A&D waiver. They are not intended to be duplicative in nature. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. The companion care proposed definition is "In-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed." The homemaker service proposed definition is: "Homemaker services consist of performing for the participant, or assisting him with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks."
Will the proposed qualification under adult companion care, as it relates to a waiver provider caring for a relative, prevent her from providing residential habilitation to her adult child?	No, this provision does not apply to residential habilitation.
Adult Day Health	
Why were the IDAPA references to the plan of service removed from Adult Day Care?	The Department removed "These activities need to be identified on the plan of service" from the DD waiver definition because the requirement is also in 16.03.10.513.
Adult Day Health should not be used as a substitute for therapy on the DD Waiver. People going to adult day health may lose their skills and regress.	The Department agrees that Adult Day Health and Developmental Therapy (DT) are two distinct services and should not be used as a substitute for each other. No changes to this service are proposed at this time.
Behavioral Consultation/Psychiatric Consultation	
The IDHW stated the basis for the removal was because the service was not used. There are many individuals with a psychiatric diagnosis on the A&D waiver. The issue may be more the willingness to authorize the service than	Idaho Medicaid offers a number of mental health services to ensure the needs of those with mental health conditions are being met. These services include the following:

the actual need for the service. Perhaps the IDHW should ask why the service is not being utilized before it is removed.	1) Inpatient psychiatric hospital services 2) Mental health clinic services 3) Enhanced outpatient mental health services (psychosocial rehabilitation skill training, community reintegration, partial care services, psychotherapy, and crisis intervention services)
Environmental Accessibility Adaptations	
People that live in "Rented" homes cannot afford to own their home. I hate to see limited environmental adaptations just because it is a "rental".	The Department has modified its proposed definition to state: b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by participant or the participant's non-paid family. Portable or non-stationary modifications will continue to be allowed.
Permanent vs. Portable or Non-Stationary Modifications. Please make sure that is clear in the rule changes. Maybe if something can be moved and go with the person, then it should still be permitted.	
What will happen when someone needs a portable environmental accessibility adaptation?	
The proposed change would limit permanent modifications to a home that is owned by the participant or a non-paid family member. Family members can be paid minimal amounts e.g., as a community support worker under the DD self-directed waiver, while their adult son or daughter lives with them. There does not seem to be a reason to exclude the home of family members who are paid and this qualifier does not appear in some of the other sections which mention home ownership. Also, exceptions should be made for long term relationships, such as living with a non-family member who is a guardian or who has cared for the individual for many years.	Waiver service definitions and qualifications do not apply to DD participants who self-direct their services.
Supported Employment	
Supported Employment needs changes. Make sure that providers and public are on board for this service. Employment services under the waiver are not accessible, because adult day care is cheaper. Supported employment participants are the first that lost their jobs. Voc Rehab does not see support from Medicaid supported employment, due to the lack of funding. Reconsider how this is funded. If you aren't going to fund and support it, then why is it offered?	The Department agrees that Supported Employment is a valuable service as evidenced by its inclusion in both the DD and A&D waivers. Currently the Department is participating with the DD Council's Collaborative Work Group for adult DD services. Supported employment and improvements in these services is one of the areas being addressed by this group.
Sometimes, people lose jobs because supported employment is not deemed "medically necessary."	
Why does DD not require TBI Training?	Supported Employment on the A&D waiver is provided to individuals with Traumatic Brain Injuries (TBIs). On the DD waiver, because Supported Employment is more likely to be provided to individuals who have disabilities other than TBIs, it is not required for all providers of this service to have TBI training.
Non-Medical Transportation	
What does the phrase "Whenever **possible**, family, neighbors, friends, or community agencies that can provide this service without charge or public transit providers will be utilized" mean? Suggested a change to say "when available".	The Department adopted this language from the Centers for Medicare and Medicaid (CMS) technical guide definition for non-medical transportation services.

Not allowing an escort may prevent some people from receiving transportation. Some people require an escort to be transported safely.	As indicated in the service plan, services may be authorized to address a participant's additional needs while receiving non-medical transportation services. Providers may ride with participants to address their needs for supported living, attendant care, and developmental therapy.
Home Delivered Meals	
In subsection d, who is going to determine if it is a balanced meal? Is that meal prepared with staff present or by participant on their own? Who follows up to see that special diet is adhered to? I fear that the burden of proof or coordination will fall to the Service Coordinator. Please offer more clarification as to the expectations of this change.	The Department has modified its proposed definition From: d. Are unable to prepare a balanced meal. To: d. Is unable to prepare a meal without assistance.
Should delivery drivers be required to have a valid driver's license?	All drivers are required to have a license in Idaho.
Respite	
Maybe remove subsection a from respite provider qualifications.	The Department has removed subsection a from its proposed provider qualifications.
Personal Emergency Response System	
The proposed change is also limited to the home of participant or unpaid caregiver. Again for individuals who reside with a parent, the parent can be paid minimally and it would seem that to limit it is not justified as the person is still alone for significant times and could be in danger.	Certified Family Home rules require that the home must provide appropriate, adequate supervision of a participant for 24 hours a day, Therefore, PERS is considered a duplication of service.
Specialized Medical Equipment	
Who decides if specialized medical equipment is cost effective?	The Department will review the cost-effectiveness of specialized medical equipment. Both price and effectiveness in meeting the participant's needs will be considered. The Department has modified its proposed provider qualifications. From: The equipment must be the most cost effective option to meet the participant's needs. To: Preference will be given to equipment and supplies that are the most cost effective option to meet the participant's needs.
The Specialized Medical Equipment provider qualifications say "The equipment must be the most cost effective option to meet the participant's needs." Change the wording from "must" to "preference will be given to the most cost effective option when available."	
The definition should clarify that this can be used to authorize items such as car seats and lifts, etc. Idaho's Medicaid program recognizes this coverage as it stated in its Idaho Home Choice Participant manual discussing A&D waiver services.	The Department authorizes lift chairs and van lifts under Environmental Accessibility Adaptations "Such adaptations may include: The installation of ramps and lifts..."
<u>Specialized medical equipment category of services</u> Idaho's Aged and Disabled waiver specifically states in Appendix C that one of the participant services offered is Specialized Medical Equipment and Supplies. This service is defined as including devices, controls or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live." The administrative rule regarding services provided that is included in the section entitled, 'AGED AND DISABLED WAIVER SERVICES: COVERAGE AND	The language in IDAPA 16.03.10.326 has been updated to make it clear that specialized medical equipment is covered as a waiver service.

LIMITATIONS," does not include this category of service. IDAPA Section 16.03.10.326 lists 18 services, but does not list specialized medical equipment. Given the scope and importance of this service as defined in the waiver and its necessity to enable recipients to live in the community, the rule should be amended to conform to the waiver requirements. As stated above, it should also be clarified that the service covers adaptations to vehicles.	
Miscellaneous	
This is all on the wrong track. You cannot try to align these rules, waivers or definitions when you serve such different populations.	Medicaid wishes to align the two waivers to make them as consistent as possible, keeping in mind the different nature of the populations.
While you are aligning services, definitions and the waivers, locations should also be aligned. Residential Assisted Living Facilities (RALF's) should be permitted to serve participants on the DD waiver.	Medicaid will not seek to include the delivery of DD waiver services to residential assisted living facilities at this time.
Other	
These following comments are beyond the scope of the negotiated rulemaking.	

a. Maintenance needs allowances

Although Federal law requires states to assess a participant contribution for special Medicaid eligibility recipients residing in facilities and in the community on 1915(c) waivers, the law also requires States to deduct from the waiver recipients' countable income an amount for maintenance needs in the community. The purpose of this deduction is to allow the individual enough income to maintain a residence in the community. Although the law allows states to individually determine this amount, it also requires that it must be based upon a reasonable assessment of the Medicaid recipient's needs. The Center for Medicare and Medicaid (CMS) acknowledges that the majority of states have set this maintenance needs allowance at three times the federal benefit rate or $2,094. *Instructions, Technical Guide and Review Criteria,* p. 93, Centers for Medicare and Medicaid Services, 2008. ("Many states have set their maintenance allowance for the waiver participant at three times the SSI Federal Benefit Rate (FBR), effectively protecting all of the individual's income for his or her own use,) *See also Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards,* AARP Policy Institute, 2010.

In Idaho, however, the maintenance needs allowances are set well below the majority of the states. Idaho refers to this allowance as a personal needs allowance or PNA. Currently, the PNAs are et based upon the recipient's marital status and responsibility for housing costs. A single, A&D waiver recipient who pays rent or has a mortgage, is allowed a PNA of $1,048, per month for food, clothes, over-the-counter medications, utilities, mortgage or rent, repairs, trash removal, etc. Single A&D waiver recipients who do not pay for housing have a deduction of the SSI Federal Benefit Rate (FBR), or $698. Both are low maintenance allowances but the rate for those paying rent or mortgages is perhaps the most burdensome. The single person with no rent has the $698, to pay for food, clothing and other expenses. If it is assumed that the $698, allowance is a reasonable amount for a PNA to meet one's needs for food, clothes and other community expenses without housing, and this amount is subtracted from the PNA for the single recipient who pays rent or a mortgage, the latter has available only $350, to cover the rent or mortgage, plus all the associated costs of home ownership. This is an unreasonably low PNA. One thousand dollars is just not enough to allow community living, especially since many A&D waiver recipients are slightly over the income limit to qualify for subsidized housing.
Additionally, married recipients who are both eligible for the waiver have a deduction of $2094, even though they only have one rent. A community spouse of an institutionalized recipient has a maintenance needs allowance of $1,838.75.

A&D waiver recipients also pay a significantly higher monthly share than other Medicaid recipients subject to different cost sharing programs. Individuals eligible under the Developmental Disabilities waiver are allowed a maintenance deduction of three times the FBR, or $2094. The vast majority of individuals who have earned income and can buy into Medicaid eligibility pay a premium of only $10, per month, The small percentage of Medicaid for Workers with Disabilities eligible recipients that pay more do so only if their income exceeds $27,000, per year.

The result of the standards set by the waiver application is that A&D waiver recipients pay a far higher monthly cost share than any other Medicaid recipient. A single recipient who pays rent or has a mortgage must live on $1048, per month. This is equal to an income of $12,000, per year, well below the poverty level. It is not the intent of the federal waiver program to require individuals with disabilities to live in poverty, it is the intent to assist them in maintaining a home in the community. This is not possible for many individuals who either go without the necessary array of services or who do not even accept Medicaid eligibility because of the high monthly cost share. Some individuals are forced to live in assisted living or nursing home facilities where the cost of the person's maintenance, e.g., rent, services, medications and other medical needs, and paid by Medicaid.

b. Incurred Medical Expenses

Federal regulation and Idaho's waiver application require deductions from an individual's countable income of incurred medical expenses. These are *all* necessary medical and remedial expenses not covered by a third party. This definition is very broad and reflects the purpose of the deductions, which is to allow individuals who live in the community and have a participant contribution enough income to meet their medical and remedial expenses. States can set some limitations on these deductions, but the limitations must be included in the waiver application. Idaho's waiver application does not specify any limitations.

I have limited experience in working with self-reliance specialists in processing requests for incurred medical expenses, yet even in this small sample, I have witnessed a great deal of inconsistency and misunderstanding when allowing for these deductions. For example, a self-reliance specialist might refuse a requested deduction based on an existing Medicaid rule limiting payment for this type of expense. This basis is erroneous, however, because incurred medical expenses by definition are medical expenses not covered by a third party. Hence, if Medicaid denies the expense arid it qualities as medical or remedial, it should be allowed.

Other areas of inconsistency I have been aware of are: authorizing transportation costs, e.g., not allowing them because Medicaid transportation, although costly, *might be* available, even though the Medicaid's Long Term Care Manual allows for transportation as a remedial expense; service animal expenses, e.g., use of the AABD rule requiring licensing of the animal (contrasting to a Medicaid BLOG setting forth a different standard) and therefore, denying expenses for service animals approved under the Fair Housing Act even though this is a community living program allowing for all necessary Medicaid expenses (AABD rules identify service animals for therapy purposes as medical); denying expenses even though an individual presented both sides of a cancelled check made out to the provider and a bill; denying expenses because the bill had been sent to a collection agency and the individual was paying the collection agency and not the provider; denying prescribed sunglasses necessary for an eye condition because Medicaid would not pay for tinted lenses; differing standards regarding how and when expenses need to be presented to the self-reliance worker, e.g., accepting one receipt for recurring monthly expenses versus requiring a receipt every month; and a lack of understanding that medical and remedial expenses can be covered and what might be considered 'remedial expenses'.

To the extent possible, clarification needs to be provided in the waiver application or rule. The inconsistency and denial of justified expenses has a significantly detrimental effect on individual's ability to afford to live in the community.

c. Over-the-counter medications as incurred medical expenses

The waiver and the corresponding administrative rule, IDAPA 16.03.18.400.07, state that over-the-counter medications are included in the PNA or maintenance allowance. Neither specifies that if over-the-counter medications are prescribed by a physician, these expenses can be deducted as incurred medical expenses. An October 3, 2011, Process and Policy Release Note regarding the Benefits Processing eManual clarified that, "prescribed over-the-counter medications are now allowed, for all programs." Whether this is a change in policy or not, the administrative rule should be amended to read that over-the-counter medications prescribed by a physician can be deducted as incurred medical expenses.

d. Guardianship and trust fees

The waiver application only allows for a fee of $25 dollars per month to pay a guardian or trustee. This amount is very low given today's standards. This low monetary figure is a barrier to recipients receiving quality services if it is necessary for the individual to be represented by a guardian or conservator.