Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF LONG TERM CARE

1 WEST WILSON STREET
PO BOX 7851
MADISON WI 53707-7851

Telephone: 608-266-0036
FAX: 608-266-2713
TTY: 888-241-9432
dhs.wisconsin.gov

Overview of Proposed Changes to Family Care Waivers and Draft Transition Plan to Comply with CMS Rules Related to Home and Community-Based Settings

Stakeholder Teleconference Briefing
July 30, 2014
Agenda

I. Welcome and Review Purpose and Format of Call
Margaret Kristan, Director, Office of Family Care Expansion

II. General Overview of Waivers — Margaret Kristan

- "Waivers" are agreements between the State and CMS that allow certain Medicaid programs to operate in ways that depart from traditional fee-for-service federal Medicaid requirements.
- Waivers for Family Care: § 1915 (b) and (c)
- 1915(b) waivers specify delivery of services through managed care and scope of services (some State Plan and 1915(c) waiver services) included.
- 1915(c) waivers specify target groups served and which home and community-based services are included to address people's long-term care needs.
- 1915(c) waiver requires that Family Care have a 5-year transition plan to come into compliance with the final CMS home and community-based settings rule.
- Both the 1915 (b) and (c) waiver renewal applications and the draft transition plan must be submitted to CMS by October 2, 2014.

III. Family Care Transition Plan (Attachment 1) — Diane Poole

IV. 1915(c) Waiver (Attachments 2-4) — Diane Poole

V. 1915(b) Waiver (Attachment 5) — Diane Poole

VI. Public Review and Comment — Margaret Kristan

- DHS is seeking public input on both waiver applications and the transition plan.
- Both waivers and the draft transition plan will be posted on the DHS website.
- 30-day review and comment period
- Comments must be submitted in writing to the DHS OFCE mailbox.
- Documents and description of input process can be found at www.dhs.wisconsin.gov/LTCare/StateFedReqs/waiver.htm.

VII. Implications for IRIS and Legacy Waivers — Camille Rodriguez

Attachments are only intended to guide the stakeholder meeting discussion. The official draft Family Care Waiver Renewal Applications and Transition Plan will be posted for public comment at www.dhs.wisconsin.gov/LTCare/StateFedReqs/waiver.htm on July 30, 2014.

Attachment 1
Family Care Transition Plan Summary

1.) Context

a. All settings where 1915(c) waiver services are provided must comply with the new HCBS final rule settings requirements.

b. The rule became final on March 17, 2014.

c. Family Care must submit a 5-year transition plan to come into compliance, by March 17, 2019, with the final rule with its 1915(c) waiver renewal application.

d. Written comment process

2.) Major Transition Activities

a. Preliminary Assessment of all 1915(c) waiver services

b. Provider Self-Assessment with MCO and State Validation

c. Provider Remediation

d. Member Transitions

3.) Timeframes

a. All settings must be compliant by March 17, 2019 – no flexibility in this date

b. Highest priorities in setting dates

4.) Implications for IRIS

Attachment 2
Summary of Significant Changes to the 1915(c) Waiver

Target Groups

- CMS will now allow states to combine target groups. Therefore, DHS has combined the three Family Care target groups into one waiver [previously two waivers – Developmentally Disabled (DD) and Frail Elderly/Physically Disabled (FE/PD)]. Combining target groups has no effect on members served, but does eliminate administrative redundancies.

Eligibility Requirements

- Changed financial eligibility requirements to remove Group C and replace with a new subset of Group B.
  - Those affected meet all eligibility criteria except for having modest income levels over the special income limit. They are generally frail elders who have some modest retirement income beyond Social Security.
  - Currently, these individuals must spend down monthly to the medically needy income limit of $592.
  - This often results in use of institutions or substitute care settings because they are not left with sufficient income to meet their basic needs at home.

- The new subset of Group B is called "medically needy with spend down."
  - For people at the nursing home level of care if, after deducting the cost of institutional care from their income, their remaining income is less than or equal to the medically needy income limit, they are eligible.
  - Cost share is based on their total income. Most will pay the entire amount of their income over the special income limit as cost share.

- This change will allow such persons to set aside income for their basic needs and allow them to remain at home.

Participant Safeguards

CMS requires states to assure proper oversight over members' health and safety. The following changes were made to provide this assurance in areas specified by CMS:

- Changed "critical incident/adverse event" to CMS terminology "Incident Management System."
- Created "DHS Reportable Incident Categories" to assure consistent reporting between MCOs and to track trends.
- Added MCO contract language to meet CMS requirement for member/guardian education on abuse, neglect and exploitation.
- Changed incident reporting from quarterly to monthly to assure timely State oversight response.

- Added incident management system review standards to External Quality Review Organization's (MetaStar's) annual review.
- Added State oversight process for restrictive measures for members who are frail elders or members with physical disabilities in unlicensed settings so that all restrictive measures for all target groups in all settings will require State review and approval.
- Required managed care organizations to report monthly on approved and unapproved restrictive measures.

Other

- Added language to demonstrate areas in which current practices satisfy the requirements of the new HCBS Final Rule (e.g., clarified that services furnished under the member care plan are based on a member-centered approach).
- Updated numerous areas of waiver to reflect current practices.

Attachment 3
Summary of New 1915(c) Waiver Services

1) Training Services for Unpaid Caregivers

- Goal is to give unpaid caregivers an opportunity to receive training that is directly related to their role in supporting the member in areas specified in the service plan.
- Removes barriers that might otherwise interfere with the MCO's ability to secure and maintain the support of unpaid caregivers.
- Could result in higher quality care for the member. For example, a family member could attend a course on how to better meet the member's needs, such as how to handle complex behaviors or a serious medical condition.

2) Consultative Clinical and Therapeutic Services for Caregivers

- Purpose is to improve the ability of unpaid caregivers and paid direct support staff to follow through on therapeutic interventions.
- Provides paid and unpaid caregivers clinical consultative services to address the member's needs.
  - Applicable when a member is relocating and new caregivers need clinical consultation on the member's behaviors and behavioral support plan or highly complex needs.
  - Could help pay for some of the upfront costs that residential facilities incur when a member with complex needs is relocating, as well as the clinical consultation that is needed regularly for some members.
  - Could be used to train providers on techniques to deescalate situations instead of calling law enforcement, possibly avoiding a hospitalization and/or loss of community placement.

3) Peer Recovery Support Services

- Recovery from mental health conditions is facilitated by social support, such as the support provided by peer specialists. Peer recovery support services help people become and stay engaged in the recovery process and reduce the likelihood of relapse.
- Extends the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.
- Could decrease the need for more costly professional interventions.

Attachment 4
Summary of Significant Revisions to Existing 1915(c) Waiver Services

1.) Day Habilitation – (Habilitation – Day Center Service)

- Added language that activities may include training or supports related to preventing or slowing progression of degenerative conditions (such as dementia).

2.) Prevocational Services

- Revised to directly reflect CMS language:
  - Creates a path to integrated community-based employment for which a person is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities. (Subminimum wage agreements would no longer be permissible.)
  - Emphasized that options for community-based employment and path to integrated community-based employment must be part of member-centered plan. Requires review every six months.
  - May be furnished in a variety of locations in the community.

3.) Respite

- Removed "respite care may be provided in an institutional setting…" to comply with HCBS Final Rule.

4.) Supported Employment

- Revised to reflect CMS core service definitions (e.g., "microenterprises" instead of "home-based self-employment," "work incentive benefits counseling" instead of "benefits management").
- Broken out into <u>two</u> separate services per recommendation from CMS (distinguishes number of people served at one time):
  - Supportive employment – small group employment.
  - Supported employment – individual employment support.

5.) Skilled Nursing

- Modified to fill gap in coverage of nursing services by covering nursing services that fall below the Medicaid State Plan Private Duty Nursing benefit and above nursing services provided by a home health agency.

6.) Financial Management Services

- Replaced "family members" with "member, guardian or <u>other authorized representative</u>" when describing who can authorize payment for services. (This is a fraud and abuse prevention measure by having guardians or POA who have legal fiduciary responsibility authorizing payment.)

7.) Adaptive Aids
- Added language to include initial purchase and routine veterinary costs (parameters to be specified in a technical assistance memo) for a certified service dog in approved circumstances.

8.) Adult Residential Care – Community-Based Residential Facility (CBRF)
- Updated to reflect Family Care policy on the maximum number of people with an intellectual disability who can live in a single CBRF facility (up to 8).
- Decreased number of nursing care hours to comply with Wis. Stat. § 50.01 and Wis. Admin. Code § 83.27.

9.) Communication Aids
- Expanded definition to include assistive technologies based on the CMS core service definition.
- Assistive technologies are used to increase, maintain or improve functional capabilities of people with disabilities through less reliance on human supports and are used extensively in employment. These technologies may be used when determined necessary through the Resource Allocation Decision (RAD) process.

10.) Environmental Accessibility Adaptations (Home Modifications)
- Updated provider qualifications and standards to prevent fraud and abuse:
  - Must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
  - All modifications must be made in accordance with any applicable local and state housing building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

11.) Habilitation – Day Services for Children (removing this service because it is irrelevant to adults)
- Current definition in Family Care limits this service to persons between 17 years, 9 months to 18 years (presumably while a Family Care application is pending). However, Family Care eligibility is limited to persons age 18 and above.
- The Children's Long Term Support waiver is available through 18 years old in areas with Family Care, so people transitioning to the adult system will not have a gap in day services. Therefore, this service is not necessary.

12.) Relocation Services
- Added exclusion for housekeeping services provided after occupancy, which are covered under supportive home care.

13.) Self-Directed Personal Care
- Added provision allowing "Personal Retainer Payments" pursuant to Olmstead Letter No.3, Attachment 3-c, services may include personal assistance retainer payments for up to 15 consecutive days to a worker providing personal care services while a member is temporarily hospitalized, or otherwise away from home.

14.) Coverage of Over-the-Counter (OTC) Medications and Nutritional Supplements

- Changed coverage of OTCs to be consistent with the State Plan by requiring a prescription.
- Eliminated coverage of nutritional supplements which are not regulated by the Federal Drug Administration (FDA) as drugs. Instead, member purchase of supplements can be used as a medical/remedial expense when prescribed by a physician.

15.) Supportive Home Care

- Added provision allowing "Personal Retainer Payments" Pursuant to Olmstead Letter No.3, Attachment 3-c, services may include personal assistance retainer payments for up to 15 consecutive days to a worker providing supportive home care services while a member is temporarily hospitalized, or otherwise away from home.

16.) Vocational Futures Planning and Supports

- Revised to reflect CMS core service definitions (e.g., "microenterprises" instead of "home-based self-employment," "work incentive benefits counseling" instead of "benefits management").

Attachment 5
Summary of Significant Changes to the 1915(b) Waiver

- CMS is now allowing states to align timelines for 1915(b) waivers with 1915(c) waivers. Therefore, DHS has changed the 1915(b) waiver period from 2 years to 5 years (1/1/15-12/31/19). The 1915(b) waiver will now align with 1915(c) waiver.

- Updated to reflect expansion into the northeast Wisconsin counties (Brown, Door, Kewaunee, Marinette, Menominee, Oconto and Shawano).

- Clarified that Family Care will cover mental health services under the emergency services benefit.

- Updated to reflect current oversight and monitoring activities (i.e., added External Quality Review Organization's appeal and grievance hotline and monthly/quarterly reports from the contracted ombudsman program, etc.).

- Updated program costs to include estimates for new 1915(c) waiver services: Consultative Clinical and Therapeutic Services for Caregivers, Peer Recovery Support Services, and Training and Counseling Services for Unpaid Caregivers.

- Updated list of services included in 1915(b) waiver to reflect new coverage of all State plan mental health and substance abuse services provided on an inpatient or outpatient basis. New services include the following:

    - Mental Health counseling and therapy provided by a psychiatrist or on an inpatient basis;
    - Mental Health inpatient psychiatric or substance abuse care in an acute care general hospital;
    - Mental health inpatient care in an IMD for persons age 18-20 and over age 64;
    - AODA treatment by a physician;
    - Comprehensive community services;
    - Crisis intervention; and
    - Outpatient hospital mental health and substance abuse services.