Home and Community-Based Waiver Program

Hennepin County

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Executive Summary

With the recent budget crisis at both the national and state level, programs such as the Home and Community-Based Waiver have been re-evaluated. Hennepin County’s role has changed in this program as well; moving from a direct service provider to an administrator. The State has mandated that every person in the each of the 87 counties in Minnesota have access to the same quality of care, in addition to other mandates. As a result, much of the paid services are moving to managed care providers for the waiver programs.

Hennepin County is looking to other states to see what they have done to ensure payment of administration while allowing others to provide direct services. Our group will be looking at five states in particular to see what changes could be adapted to improve efficiency, secure funding, and ensure care is maintained to those who use the program.

Methodology

The nature of our research is a comparative study. Our methods of data collection included document research and review, and interviews with various stakeholders.

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Hennepin County

Hennepin County Human Services and Public Health Department (HSPHD) is a newly formed agency in Hennepin County. Previously, it was two separate departments: Human Services and Public Health. More recently, the two were merged to better streamline the County’s administration of services. This department is charged with administration of the Home and Community-Based Waiver programs.

Hennepin County is home to over one in five Minnesotans. In 2008, the population of Hennepin County was estimated to be 1,140,988 while Minnesota was estimated at 5,220,3932. Measuring only 556.62 square miles, Hennepin County has more people per square mile than any other county in the state of Minnesota, coming in at nearly 2,004 people per square mile3. Population estimates for the elderly and disabled population in Hennepin County are expected to grow at a rapid rate given that baby boomers are entering their retirement years.

Home and Community-Based Waivers

Hennepin County has the responsibility of carrying out administration and services for the Home and Community-Based Waiver program for the elderly and disabled populations. This program is administered by the County with funding from the State and Federal governments. They are programs of CMS (Centers for Medicare and Medicaid)4. The programs are for those who would otherwise be committed to a nursing home or an Institutional Care Facility for the

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Mentally Retarded (ICF-MR) to be able to receive comprehensive care services in their homes so that they can remain in their community. CMS operates these programs because it has shown it saves money. That being said, the cost of services is capped at what it would cost to have that person living in a nursing home or ICF-MR rather than their community.

Centers for Medicaid and Medicare Services (CMS) operates under the Federal U.S. Department of Health and Human Services. CMS is currently creating a repository of Promising Practices in Home and Community-Based Services (HCBS) to highlight state efforts that enable persons of any age who have a disability or long-term illness to live in the most integrated community setting appropriate to their individual support requirements and preferences, exercise meaningful choices, and obtain quality services.

The term “waiver” refers to an exception to federal law that is granted by CMS. Waivers allow participants, who have disabilities and chronic conditions, to have more control of their lives and remain active participants in their community. Without these waivers, many consumers would live in a hospital, nursing home, or Institutional Care Facility for the Mentally Retarded (ICF-MR).

HCBS Waivers Section 1915(c)

States may offer a variety of services to consumers under a Home and Community-Based Services (HCBS) waiver program. The number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental

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services, skilled nursing services) as well as non-medical services (i.e. respite, case management, and environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general, spouses and parents of minor children cannot be paid providers of waiver services. States have the discretion to choose the number of consumers to serve in a HCBS waiver program, but must apply through CMS. Once approved by CMS, a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval.

**Application and Approval Process**

The State Medicaid agency must submit to CMS for review and approval an application for an HCBS waiver, and the State Medicaid Agency has the ultimate responsibility for an HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity. Initial HCBS waivers are approved for a three-year period, and waivers are renewed for five-year intervals.

**Program Requirements**

Within the parameters of broad Federal guidelines, States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement an HCBS waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measure will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
• Ensuring that services are provided in accordance with a plan of care.

**Literature Review**

When scanning the broad field of long term care, aging, and disability, there is a lot of information available. The search turns up a range of information including adult protection services, nursing home services, financial wealth management for the aging, health care coverage, and various health care and community services provided to a variety of populations. This information is written and produced in various forms by a variety of organizations including health care associations, government entities, independent authors and publishing houses, and educational organizations. While this information is important and relevant to services Hennepin County provides to its elderly and disabled population, this report is more specific. In order to complete a more relevant research report, we narrowed down our focus to the Home and Community-Based Waiver programs from The Centers for Medicare and Medicaid (CMS).

When narrowing the literature search to the Home and Community-Based Waiver programs we found there is very little literature available on these specific programs. The review included a survey of books, articles, reports, and websites and we even found ourselves in the basement of the Wilkins library in the old government section searching documents on microfiche. Some microfiche documents we found were waiver restructure plan for alternative care services and elderly waiver, and a rate consolidation for the payment of alternative care services. HCBS’s are mentioned in books like *The Complete Guide to Medicaid and Nursing*

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7 Minnesota Dept. of Human Services. Home and Community Based Services Division. Waiver restructure plan for alternative care services, elderly waiver, community alternative care services, community alternatives for disabled individuals services and traumatic brain injury waiver services. St Paul, Minn. 1995

8 Minnesota Dept. of Human Services. Home and Community Based Services Division. Rate consolidation for the payment of alternative care services, elderly waiver services, community alternative care services, community alternatives for disabled individuals services and traumatic brain injury waiver services. St. Paul, Minn. 1995.
Home Costs\(^9\), but these books are focused on the end users of the services which is not our focus. Of the pertinent literature we found, the most prominent information came from reports conducted by consulting groups for various governments and associations who support and/or offer services to the aging and disabled populations. The Lewin Group did a report in 2008 at the NASHP (National Academy for State Health Policy) Conference summarizing how effective HCBS programs are in the United States and they are effective at saving money. This report includes specific information on Colorado, Oregon, Washington, Wisconsin, and Minnesota\(^{10}\). There are also a handful of websites which offer information regarding HCBS programs like The Clearinghouse for Home and Community Based Services\(^{11}\). Another fruitful area is the employees who work within the governmental systems of the county’s aging and disabled social services areas. Although it was difficult to find and make the initial contact with the bureaucrats, we were successful in conducting interviews with two of them in the states of Washington and New York, and we also made contact locally in Minnesota.

Since the HCBS program is a Federal government program offered from Medicaid we expected to see much more research that would be available. One reason for the lack of research may be that these are very specific programs that were recently implemented; recent being in the 1980’s. Although this is about a 30-year span, it is still a relatively new program for a Federal government initiative. With the aging and disabled population growing at such a rapid rate and increasing costs of nursing home placement, we expect more research to be done in the area of these programs, and this would be a good area to develop more academic research.

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\(^9\) Russell, Joan M. Atlantic Publishing Group, Inc; Ocala. 2008.  
\(^{11}\) The Clearinghouse for Home and Community Based Services. [http://www hcbs.org](http://www.hcbs.org/)
Even though narrowing the scope of research to this degree limited our available materials, it was important to our client who specifically wanted to find alternative ways of operating this program. The client requested research to compare and contrast alternative approaches to find ideas and best practices for securing funding for the administration of the waiver programs. In addition to narrowing the scope to Home and Community-Based Waivers, we also limited our search to information that included business administration of the programs. The interest in understanding the services provided was important to understanding the entire top level of the program, however, our focus is on the administration of the HCBS waiver. A guest speaker in the policy classes at the University of Minnesota, Kelly Harder, Steele County Human Services Director provided much in-depth information on how counties in Minnesota operate from a business and systems administration perspective.

We found some of the most important waiver information was received from our client, and information accessed from CMS (The Center for Medicare and Medicaid)\textsuperscript{12}.

\textsuperscript{12} Centers for Medicaid and Medicare. 2009. \url{http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/}
Analyses of Current Implementation

California

Between 2010 and 2040, the population of individuals age 60 and over will double in the state of California. With the current economic climate, the cost of providing human services to this growing population is of great concern. Budget deficits are already cutting programs to seniors, thus leaving mostly basic services available.

California utilizes a number of waivers for different population such as the AIDS Waiver and Multipurpose Senior Services Program (MSSP) focused on seniors aged 65 and over. This waiver is especially important considering the expected doubling of the senior population in the next 30 years. MSSP's total annual funding is $50,515,000, equating to $4,285 per MSSP client slot annually. MSSP utilizes 11,789 client slots to serve the 16,335 potential clients statewide on an annual basis. The difference between the two numbers represents client turnover during the year.

Each MSSP site receives an annual total budget based on the number of their client slots times the per client slot funding. Each site then develops a detailed budget based on prior experience and expected changes. These individual annual site budgets are submitted to California Department of Aging (CDA) for review and approval.

The approved site budget is divided into three categories: care management, care management support (these two areas are combined to become the waiver service care management), and waiver services--this is composed of all the other services that can be provided under the waiver: transportation, adult day support, meal service, protective services, special communications, housing assistance, in-home support services and respite.

The Care Management (CM) category represents the costs for the CM staffing (NCMs, SWCMs, etc.). CM support represents the associated costs to support CM such as office space and travel costs (e.g. administrative costs). Rates are developed for CM and CM support by dividing the number of months and client slots into the total anticipated costs. Sites then bill for these two categories (and waiver services) through the California Medicaid Management Information System (CAMMIS) (operated by California’s fiscal intermediary, Electronic Data Systems [EDS]) to receive reimbursement during the year. In the final months of the waiver year, site fiscal staff adjust billings to correct for staff and client changes during the year in order to assure that billings are only for actual costs. Annual closeouts are submitted to CDA for review and approval. The closeouts are also audited by CDA auditors to assure that the billings reflect only actual and true costs.16

Waiver services are the services purchased for the clients by the MSSP sites from local service vendors. MSSP sites negotiate these rates locally based on community norms and pass those actual costs on by billing those same amounts through CAMMIS.

All MSSP claims are subject to the CAMMIS edits and audits. In addition, billings are monitored on an ongoing basis by CDA staff. Each MSSP site’s expenditures are capped in

16 Supra note 14
CAMMIS with the site’s total budget so that no site can spend over their total budgeted amount.

Each MSSP site fiscal system is audited for each year by CDA auditors to assure that the billings submitted to CAMMIS reflect actual and true costs incurred in MSSP operations.17

MSSP claims flow directly from the MSSP sites to California's claims payment system for adjudication and payment. The MSSP Care Manager is responsible for prior authorization of all MSSP Waiver services and verifies that the requested services are in accordance with the MSSP client’s Care Plan (CP). Claims for services are paid after the service is rendered.

MSSP Waiver providers submit claims to EDS for services rendered. These claims are subject to all established requirements for processing directly through the CAMMIS system. EDS adjudicates claims for services, resulting in one of four possible actions18:

Claims passing all edits and audits are researched and approved daily. EDS forwards a payment tape weekly to the State Controller’s office for a check write and the provider is notified.

MSSP site care managers review billing documents with the site fiscal officer to assure that services are included in the approved service plan, and to verify the accuracy of the services utilized, amount, and date(s) services were provided.

EDS performs routine and ad hoc claim reviews (edits and audits) to assure that payment is only made when the individual was eligible for Medicaid waiver payment. CDA staff, during utilization reviews, review a sampling of MSSP site and client records to assure adequate documentation exists to validate provider billings and that billings were accurately made. MSSP

17 Supra note 14
18 Supra note 14
site fiscal systems are audited for each year by CDA auditors to assure that the billings submitted to CAMMIS reflect actual and true costs incurred in MSSP operations. Paid claims that are not valid or accurate, based upon an audit finding, will be recovered by the State.

**Applying to Become An MSSP Site**

MSSP sites must be governmental or non-profit agencies. The MSSP sites are procured through the State contracting process which involves an RFP.

**Impact on Counties**

The proposed budget for Sacramento County Health and Human Services for FY 09-10 calls for a reduction of 47.6 positions which will result in over 10,000 recipient cases without an assigned social worker (SW) to provide case management.\(^{19}\) Currently, In Home Supportive Services (IHSS) has over 4,000 recipients without an assigned SW and case management as a result of 32.0 positions cut during midyear budget. These reductions will result in increased costs to the County due to an increase in the Unfunded Impact: number of paid IHSS hours resulting from less face to face assessments, increased number of telephone assessments for readjustments of hours, increased number of IHSS recipients in residual status (increasing County payment participation to 35-percent versus 17.5 percent without residual status), and increased number of over-due renewals. Delay in timely intake assessments, thus resulting in increased need for IHSS services as applicant's health needs deteriorate without care and assistance—this was experienced in Fiscal Year 2006-07 following a period of reduced staffing because of budget

reductions. The staff reductions resulted in the creation of a "Wait List" for services—
assessments of applicants on this list resulted in a jump in average paid hours.20

Collaborations and Initiatives

Sharing information and resources is one tactic (among many others) that enables States
and Counties to ensure equitable and sufficient services to state and county residents. Two
eamples of this are the Seamless Senior Services (S3) Task Force of Los Angeles County and
the Network of Care for Sacramento County.

The S3 Task Force intends to “enhance service delivery and improve coordination
between departments” for seniors.21 The initiative identified a number of programs and services
available to seniors throughout Los Angeles County. The task force then facilitated
communications between each department in order to enhance service delivery for seniors. The
task force then held 16 stakeholder meetings with seniors and other vulnerable adults to hear
suggestions and recommendations for furthering improvement. After reviewing other agencies
within Los Angeles County as well as three other counties (San Diego, San Mateo, and San
Francisco) in California that have integrated service delivery models, the task force identified
several programs that offer an opportunity for improvement.

The key insights from studying the three counties included22:

- Integration of services allow for improved identification, and service delivery for
  senior and adults with disabilities
- Each county had a stated mission and vision statements that guided them
- Counties leveraged resources to develop greater efficiencies

20 Supra note 18
• Allowed for input on behalf of constituents and stakeholders during planning and implementation
• Allowed for greater collaboration between services for innovated service delivery

The next steps include implementing recommendations and continuing to monitor service delivery for seniors and adults with disabilities.

Sacramento County's Network of Care is a website dedicated to seniors for the purposes of information dissemination and news updates. This “comprehensive” resource allows seniors to find services within the county, follow legislation, act as a library, store important documents online, and engage in social networking. For seniors in Sacramento County looking for information about services and resources, the Network of Care website is a one-stop shop for any questions they might have.23

Both of these resources are important in that they are attempting to address a need for information dissemination and resource banks. The Network of Care website is funded by a grant from the CDA, thus allowing Sacramento County to utilize precious resources in other places. Other resources exist in the form of grants from other state agencies or private foundations. These funds can act as seed money for demonstration or pilot projects that are habitually difficult to fund via legislation.

New York

The state of New York is similar to Minnesota in that local counties are responsible for the delivery of social services. For CMS waiver programs and community-based services, there is a region based approach in the sense that the State of New York contracts with regional nonprofits to administer community-based services. The only exception is New York City, where the city administration holds authority over the counties in regards to service delivery and administrative duties.

New York administers a number of CMS approved waiver programs for DD populations and seniors needing long-term care. For the purpose of this report however, only two waiver programs will be discussed; New York Nursing Home Transition and Diversion Waiver (NHTD) and the New York Federal-State Health Reform Partnership (F-SHRP). The NHTD is authorized under section 1915(c) of CMS and is intended for seniors needing long-term care.24 The F-SHRP is a demonstration project authorized under section 1115 aimed at restructuring New York’s health care system in terms of efficiency and technology implementation.25 These programs will be discussed in more detail below.

Erie County

Erie County sits on the far western portion of New York State and borders Lake Erie to the west. With a population of just

over 900,000 people, Erie County is similar in size to Hennepin County, but does not contain a large percentage of the State's overall population. The State of New York as over 19 million residents, thus Erie County only represents approximately 5-percent of the total population. According to the U.S. Census Bureau, over 15-percent of Erie County Residents are senior citizens (65+), slightly above the national average of 13-percent.

NHTD

The Nursing Home Transition and Diversion (NHTD) Medicaid Waiver provides community-based alternatives to individuals eligible for nursing facility placement. The NHTD allows waiver participants to avoid or transition from nursing home placement.

The NHTD structure is modeled after New York’s 1915(c) Traumatic Brain Injury Medicaid Waiver. Within the first three years, this application requested to serve at least five thousand (5,000) individuals, who were eligible for nursing home care, to remain in or return to the community. Such individuals received a variety of comprehensive community-based services and supports.

The New York State Department of Health (DOH), Office of Long Term Care, Bureau of Long Term Care (BLTC) are responsible for the operation and oversight of the NHTD. The NHTD waiver is an important element of the state's effort to restructure its long term care system.

26 Erie County Quickfacts. U.S. Census Bureau. [http://quickfacts.census.gov/qfd/states/36/36029.html](http://quickfacts.census.gov/qfd/states/36/36029.html)
27 Supra note 25
28 Supra note 25
29 Supra note 23
In order to promote efficiency and allow for regional flexibility, DOH contracts with not-for-profit agencies in nine regions across the state with demonstrated experience providing community-based services to individuals with disabilities and seniors. These agencies serve as Regional Resource Development Centers (RRDCs) and employ Regional Resource Development Specialists (RRDSs). The RRDCs are responsible for determining waiver participant eligibility, reviewing Service Plans, meeting regional budgeting targets, organizing local outreach efforts, developing regional resources, making recommendations to DOH Waiver Management Staff about enrolling waiver services providers, and training service providers. In order to further assure the health and welfare of waiver participants, each RRDC employs a Nurse Evaluator (NE) who evaluates, as necessary, new waiver participants and waiver participants returning to the community for the potential need for medically related waiver services.31

In order to assure implementation of its Quality Management Program, DOH contracts with Quality Management Specialists (QMS's). These Quality Management Specialists work closely with DOH Waiver Management Staff to implement a quality management program, liaise between DOH Waiver Management Staff, RRDC's and service providers, review Service Plans that have a budget over an amount to be determined by DOH Waiver Management Staff and provide technical assistance to the RRDS's.

DOH Waiver Management Staff monitors QMS's and RRDC's (RRDS's and Nurse Evaluators) by conducting on-site visits and annual evaluations to assure they are meeting their contractual obligations.32

31 Supra note 23
32 Supra note 23
An important component to the implementation of the NHTD is the waiver participant’s right to choose a service provider, especially his/her Service Coordinator. At the regional level, RRDS's are responsible for providing unbiased and comprehensive information to enable potential waiver participants to make informed decisions about whom to choose as a Service Coordinator. The Service Coordinator is crucial to the waiver participants’ success in the community, as they work with the waiver participant in the development, implementation, and evaluation of the Service Plan. The Service Coordinator is responsible for assuring the waiver participant’s choice of other providers.

**F-SHRP**

Under F-SHRP, the State will invest up to $1.5 billion (up to $300 million per year) in agreed upon reform initiatives. The primary focus of these initiatives will be to size and restructure the acute and long-term care delivery systems, expand the use of e-prescribing, foster the implementation of electronic medical records and regional health information organizations, and expand ambulatory and primary care services.

New York will be required to meet a number of programmatic milestones during the demonstration, and demonstrate Medicaid program savings from both the health care system reforms that it will be implementing as well as expansion of managed care enrollment to additional counties in the State. New York will also be required to conduct an evaluation of the impact of the demonstration program during the 5-year period. New York
will undertake significant reforms to promote the efficient operation of the State’s health care system by:

- Reducing excess capacity in its acute care hospital industry;
- Shifting emphasis in long-term health care services from an institutional to a community-based setting consistent with the President’s New Freedom Initiative by reducing nursing home excess capacity and worker retraining;
- Investing in health information technology initiatives, including e-prescribing, electronic medical records and regional health information organizations; and reorienting New York’s health care system away from inpatient facilities to outpatient and primary-care focused delivery systems, including pay-for-performance initiatives.

Under F-SHPR, the Federal government will provide funding up to $1.5 billion (up to $300 million per year) to the State for specific designated expenditures. The Federal funds “free up” State funds for New York to invest in the reforms outlined above. However, Federal funds are conditioned upon the following:

- The State must meet a series of established performance milestones set forth in the demonstration terms and conditions; and
- The demonstration must generate Federal savings sufficient to offset the Federal investment.

**Funding of Reforms**

After incurring DSHP expenditures, the State may draw down FFP only as it is ready to expend State funds on the health reform initiatives. In essence, Federal funds replace some of the State funding for the DSHP, thereby “freeing up” State funds for New York’s health reform initiatives outlined above. Federal funds are limited to $300 million annually, and may not be rolled over into subsequent years. However, the State has two years after each demonstration

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year to claim Federal funds and pay for investment expenditures incurred during the demonstration year, which is consistent with Medicaid requirements.

**Performance Milestones**

The State must meet all milestones throughout the demonstration period. Failure to meet any milestone (except the fraud and abuse recoveries milestone) will result in cessation of FFP for DSHP. Failure to meet the fraud and abuse recoveries milestone will require New York to pay the Federal government the difference between the demonstration year goal and actual recoveries, up to a limit of $500 million over the five-year demonstration period. Additionally, if New York ends any of the initiatives implemented as part of this agreement prior to the end of the five-year demonstration, the Federal government will immediately cease providing FFP for DSHP. These milestones include:

- Increasing fraud and abuse recoveries to 1.5 percent of the State’s FFY 2005 total Medicaid expenditures by the end of the demonstration (2011);
- Implementation of a preferred drug program for the entire New York Medicaid program;
- Implementation of an employer-sponsored insurance program;
- Implementation of one new Medicaid reform initiative (exclusive of the items above); and
• Implementation of a single point-of-entry system for long-term care service assessment.

By October 31, 2006, the state was required to develop and submit to CMS its plan for achieving this milestone by the end of the demonstration period. This included details of Office of the Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources; the goal was achieved. By December 31, 2008, for the period of October 1, 2007 to September 30, 2008, the state had to demonstrate its annual levels of fraud and abuse recoveries are equal to 0.5 percent of total computable Medicaid expenditures for the federal fiscal year, or $215 million. The State’s accomplishment for FFY 07-08 was $551.6 million, which exceeded the goal by $336.6 million.\(^{34}\)

**Savings**

The reform initiatives to right-size and restructure the State’s health care delivery system and to expand use of health information technology are expected to generate significant savings to both the State and Federal government. However, these reforms will be implemented over a number of years and although some of the savings are expected to accrue in the next 5 years,

\(^{34}\) Supra note 32
much of the savings will be long term. The State is required to generate $3 billion in gross Medicaid savings ($1.5 billion Federal) over the 5-year demonstration period. Should the State not achieve these savings by the end of the demonstration, it will be required to refund to the Federal government the difference between the Federal investment in the F-SHRP reforms and the Federal savings generated.

In order to generate sufficient Federal Medicaid savings to offset its investment, CMS will count savings in two areas – savings generated due to decreased hospital utilization resulting from eliminating excess acute care capacity and savings generated through Medicaid managed care expansions. The managed care expansions include the current implementation of mandatory SSI enrollment and expansion of mandatory Medicaid enrollment in additional counties. Counting these managed care savings for F-SHRP required moving these populations from the State’s existing section 1115 demonstration, Partnership Plan, to the new F-SHRP demonstration.

**Eligibility, Enrollment, and Benefits**

The State directly contracts with commercial MCOs and State-certified Prepaid Health Services Plans (PHSPs) for the Partnership Plan. All beneficiaries in the demonstration must use providers within their managed care plan.

Managed care beneficiaries in the Partnership Plan receive the same comprehensive benefits package available under the fee-for-service program. Certain services, such as long-term care services, continue to be provided on a fee-for-service basis. Other services, such as transportation and dental care, may be provided on a fee-for-service basis or as part of the
capitated managed care service package at county discretion. Family planning services can be obtained from any provider offering such services to Medicaid beneficiaries.

The State also offers certain services on a fee-for-service wraparound basis to individuals who exceed a basic benefit threshold within their managed care plans. For example, individuals who exhaust their basic benefits as defined in the capitation rates are able to receive mental health inpatient and outpatient services, and medically necessary chemical dependency treatment services on a fee-for-service basis.

**Evaluation**

F-SHRP is a five-year demonstration that will end on September 30, 2011. Over the five-year term, the State will be required to report quarterly and annually to CMS on the progress of the demonstration. Reporting will include a number of quantifiable metrics to assist CMS in evaluating the effectiveness of the State's reforms\(^\text{35}\). In addition to the reporting requirements, a formal evaluation of the demonstration is required, with a report due to CMS when the demonstration expires.

**Role of County**

The Community Alternative Systems Agency (CASA), located in Erie County's Division of Long Term Care is staffed by employees of the Erie County Department of Social Services and Jewish Family Service. CASA's primary function is to determine the appropriateness and necessity for Medicaid long-term care services and develop suitable care plans for community based elderly and/or disabled individuals in Erie County to remain as independent as possible. In

\(^{35}\text{Supra note 23}\)
2008, CASA provided home care services to over 4,000 clients and their families. According to the 2008 Erie County Budget, for every dollar spent on benefits, $0.024 are budgeted for administration costs. While this does not necessarily include assessments, it does provide a basis of comparison for Hennepin county.

**Eligibility Requirements**

A person must meet certain program eligibility requirements to become a part of the CASA system:

- Must be a resident of Erie County.
- Must be financially eligible for New York State Medicaid.
- Must obtain a physician's medical order for home care services.

A team of Medicaid eligibility workers located within the CASA services division interview new applicants for Medicaid who are looking specifically for Home Health Care Services. They also do the annual financial eligibility reviews for each Medicaid home care recipient.

**Access and Coordination Team**

The Access and Coordination Team (ACT) is a unit designed to help consumers access appropriate community services within the Long-term Care System. ACT is committed to the coordination of quality care, community education, and the most efficient use of Medicaid resources. ACT is responsible for receiving, reviewing, and processing all new referrals for home care services.

**Getting Eligibility Established**

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After assessing the client's needs CASA arranges for home care services for its clients. CASA clients may receive a variety of services from personal care to meal preparation:

**Consumer Directed Personal Attendant Program (CDPAP)**

If a client qualifies for CASA services, they may also be eligible for assistance through the Consumer Directed Personal Attendant Program, a unique program which allows clients to recruit, hire, and supervise their own aides. Consumer directed attendants may also perform skilled nursing tasks under the consumer's direction.

**Long-term Home Health Care Program (LTHHCP)**

CASA also assesses Medicaid eligibility for clients in the LTHHCP and monitors the appropriateness of their care. LTHHCP is also referred to as a 'nursing home without walls'. The program consists of a coordinated plan of care and services that are provided at home or in adult care facilities to a person who is medically eligible for residential nursing home care. CASA also ensures that the services the LTHHCP clients receive are cost effective.

CASA is responsible for the prior approval of several Medicaid long-term care services to ensure the most appropriate, least restrictive setting and access to home-based care. This includes approving skilled nursing facilities and assisted living facility placements for all Medicaid clients.

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38 *Supra* note 35
Ohio

Medicaid is a large portion of the Ohio budget. Annually, Ohio Medicaid provides health services to 2.2 million low-income working families, children, seniors, and people with disabilities. In 2008, 70-percent of Medicaid expenditures in the state of Ohio were on elderly and disabled populations. Concurrently, the elderly and disabled populations only made up 22-percent of those who enrolled in Medicaid programs. Medicaid accounts for 3-percent of Ohio’s economy and 23-percent of total state government spending. Ohio Medicaid administers waiver programs that serve more than 72,000 individuals on average each month, including 37,000 seniors age 60 and older, 10,900 children and adults up to age 60, and 24,000 people with mental retardation or a developmental disability.

The Ohio Bureau of Community Services Policy (BCSP) is one of eight bureaus within the Office of Ohio Health Plans, Ohio Department of Jobs and Family Services. BCSP administers the Ohio Home Care program, consisting of four benefit packages of Medicaid home and community-based services, which includes two home and community-based services waiver programs. The Ohio Home Care Waiver (OHCW) program benefit package consists of nursing services, personal care assistance services and/or skilled therapy services, plus waiver-specific services such as home modifications, home-delivered meals, adult day health care, respite care,
supplemental transportation, adaptive/assistive devices, and emergency response systems.\textsuperscript{44} The Ohio Department of Job and Family Services (ODJFS) provides funding for and is ultimately responsible for all eight waivers within Ohio Medicaid, and administers three of them.\textsuperscript{45} The others are administered by the Ohio Department of Developmentally Disabled (ODDD, formerly MR/DD) which manages two waiver programs, and the Ohio Department of Aging (ODA), which manages three waiver programs.\textsuperscript{46} For each agency that is administering the care, they are also responsible for determining the level of care for each consumer.

\textbf{Waivers Administered by ODJFS}

ODJFS administers three waiver programs and contracts with a case management agency, \textit{CareStar}, to provide the necessary case management services for recipients of the home and community-based waiver programs. ODJFS monitors compliance of the waiver programs through comprehensive quality assurance programs including outcome-based customer interviews; consumer satisfaction surveys; contractor and provider site visits; and thorough review of consumer, contractor, and provider records.\textsuperscript{47} All waivers administered through ODJFS require a certain financial threshold to be eligible. The three waivers the ODJFS administers are Ohio Home Care Waiver, Transitions MRDD and Transitions Carve-Out.

\textsuperscript{44} The Ohio Home Care Waiver (OHCW) Program. Department of Job and Family Services. \url{http://jfs.ohio.gov/ohp/OhioHomeCare.stm}
\textsuperscript{45} “Medicaid Waiver Programs in Ohio”. Ohio Legal Rights Services. \url{http://olrs.ohio.gov/asp/olrs_WaiversTables.asp}
\textsuperscript{47} “About the Ohio Home Care Program”. Department of Job and Family Services. \url{http://www.ohiohcp.org/about.html}
Ohio Home Care Waiver

The Ohio Home Care Waiver (OHCW) program is designed to meet the needs of consumers requiring intermediate or skilled level of care and who are age 59 or younger. This waiver is available to new enrollees. Applicants are required to fill out the ODJFS 02399 form, which can be obtained and submitted at the local county department of job and family services (CDJFS) office. There is currently a waiting list for the OHCW, and when space becomes available, applicants on the waiting list must re-apply.

Transitions MRDD Waiver Program

The Transitions MRDD Waiver program is designed to meet the needs of consumers eligible for institutional Medicaid who have been assessed to require an ICF-MR/DD (institutional care facility for the mentally retarded/developmentally disabled) level of care. This waiver is not available to new enrollees. In order to enroll in the Transitions MRDD Waiver, the applicant must first be on the Ohio Home Care Waiver and be “transitioned” to the Transitions MRDD Waiver. This will occur when the applicant’s condition has changed to now require an ICF-MR level of care.

Transitions Carve-Out Waiver Program

The Transitions Carve-Out Waiver program is designed to meet the needs of consumers who are age 60 and older. Eligibility criteria require having either an intermediate or skilled level of care need. This waiver is not available to new enrollees. In order to enroll in the

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Transitions Carve-Out Waiver program, the applicant must first be on the Ohio Home Care Waiver and be “transitioned” to the Transitions Carve-Out Waiver due to turning 60 years old.

**CareStar**

Started in 1988, *CareStar* is a private company with their headquarters based in Cincinnati, Ohio. They operate throughout Ohio and Indiana to provide “solutions for governments, organizations, and individuals responsible for the care of consumers requiring home and community-based services”[^51]. *CareStar* is under contract with ODJFS to serve all 88 counties through four regional offices. By providing case management, CareStar also[^52]:

- Visits applicants in their homes to determine if they are eligible for home care services, and determine if they can be served safely in their homes and communities
- Help approved applicants develop their service plan and arrange for providers who can meet their needs
- Coordinate overall service provision with all involved providers and systems
- Assure consumer health and safety
- Maintain regular contact with consumer to make sure needs are still being met and that they are still eligible for services
- Troubleshoot problems for consumers
- Gather information that helps ODJFS administer home care programs

**Waivers Administered by MR/DD**

The Ohio Department of Developmental Disabilities (ODDD) administers two additional waiver programs. The level of care required of consumers of MR/DD waivers are determined by county boards. Eligibility for both waivers requires consumers of ICF-MR level of care and specific financial criteria. They do not, however, have any age specific requirements.

**Level One Waiver**

Recipients of the Level One Waiver receive an array of services from supports, to medical equipment.

[^51]: “Who We Are”. CareStar. [http://www.carestar.com/about/whoweare.asp](http://www.carestar.com/about/whoweare.asp)

[^52]: “Ohio Home Care Case Management Services”. Department of Job and Family Services. [http://jfs.ohio.gov/OHP/ohc/Facilitation.stm](http://jfs.ohio.gov/OHP/ohc/Facilitation.stm)
Completion of the JFS 02399 is required and can be obtained and submitted at the local CDJFS or at the local county board of MR/DD. The ODDD administers this waiver program under the direction of ODJFS. Contrary to waivers administered by ODJFS, those that are administered by ODDD provide case management through local county boards of MR/DD.

**Individual Options Waiver**

There are subtle differences in the services provided by the Individual Options Waiver, as opposed to the Level One Waiver. Like the Level One Waiver, the Individual Options Waiver provides similar services as well as social work, counseling, nutrition and home delivered meals and an interpreter.

Again, similar to the Level One Waiver, completion of the JFS 02399 is required to participate. This form can be obtained and submitted at the local CDJFS or at the local county board of MR/DD. The ODDD administers this waiver program under the direction of ODJFS while case management is provided by MR/DD through local county boards.

**Waivers Administered by ODA**

The Ohio Department of Aging (ODA) provides three waivers, with the level of care a patient requires being determined by Area Agencies on Aging. In order to qualify, the recipient must meet a specified financial threshold.

**PASSPORT**

The PASSPORT program is for those who need at least an intermediate level of care and are of age 60 or older. There is an array of services available to those who qualify for the

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program including adult day health, environmental accessibility adaptations, personal emergency response systems, and specialized medical equipment and supplies⁵⁴. Again, it is required that the applicant fills out the JFS 02399 form and submits it to the local CDJFS or PASSPORT Administrative Agency (PAA) offices. There is a waiting list for PASSPORT. When space becomes available, applicants on the waiting list must re-apply. The ODA administers this program under the direction of ODJFS. PAA acts as regional administrators and provide case management services to consumers.

**Assisted Living Waiver**

Recipients of the Assisted Living Waiver require at least an intermediate level of care and are either currently living in a nursing home or are enrolled in PASSPORT, CHOICES, OHCW, or Transitions Carve-Out waivers. They must also be age 21 or older and have unschedulable need for hands-on assistance with at least two activities of daily living⁵⁵. The Assisted Living Waiver provides simply that—assisted living. It also provides community transition assistance for those currently residing in a nursing home. The completion of the JFS 02399 form is required. The ODA administers this program under the direction of ODJFS. The three approved PAAs act as regional administrators and provide case management services.

**CHOICES Waiver**

Recipients of the CHOICES Waiver require at least an intermediate level of care and are age 60 or older. Those who qualify must also reside in an approved service area, being one of the three PAA areas. These consumers must also be attend training and be willing and able to

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direct provider activities and negotiate rates within a cost cap\textsuperscript{56}. There are many services that the CHOICES Waiver provides its participants.

Similar to other waiver programs, completion of the JFS 02399 form is required. The ODA administers this program under the direction of the ODJFS. The three approved PAAs act as regional administrators and provide case management services\textsuperscript{57}.


Washington

The Washington State Department of Social & Human Services (DSHS) is currently funded at approximately $9.8 billion a year which represents 34-percent of Washington's annual budget. The 2009-11 biennium budget, passed in January, approves more than $19.9 billion for the next two years, a nominal increase from the $19.4 billion approved for the previous two years (2007-09). Even with this increase in funding, services and programs will be cut as costs for services is higher than ever. Serving over 2.1 million residents, the DSHS administers services using a region-based system where the state is separated into six distinct and separate regions that provide services and assistance. As seen below, King County, the most populous county in Washington State, is one region. King County is home to Seattle, Washington's largest city and approximately 30-percent of the state's population.

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59 Supra Note 1
DSHS supports a number of waiver programs, but for the purpose of this report, only waivers utilized by the Division of Developmental Disabilities (DDD) located within the Aging and Disability Services Administration (ADSA) of the DSHS will be reported on. The reasoning behind this decision is that it allows for a more focused analysis and accurate financial tracking.

**DDD Info**

The mission of DDD is to make a positive difference in the lives of people eligible for services through offering quality supports and services that are individual and family driven, stable and flexible, satisfying to clients and their families, and tailored to individual needs. Supports and services are offered in ways that persons with developmental disabilities can make informed decisions about their options and provide optimum opportunities for success. Case resource managers and social workers located in offices around the state conduct assessments; provide intake and eligibility determination, and offer ongoing case and resource management.

Services administered by DDD include community residential services, including certified services such as supported living, group homes, companion homes, and alternative living and licensed services such as Adult Residential Care and Adult Family Homes; employment and day program services; professional services such as physical, occupational, and speech therapies, behavior management, counseling, nursing, and nurse delegation; and in-home services such as personal care, Individual and Family Services, and medically intensive home care. These services are administered through the State Plan, state-only funding, and/or one of five Home and Community Based Service waivers.

DDD operates five Residential Habilitation Centers (RHC) and four State-Operated Living Alternatives Supported Programs (SOLA). DDD also administers several specialized
programs, including the Voluntary Placement Program (foster care), the Community Protection Program, and the Developmental Disabilities/Mental Health Collaborative Plan. DDD administers the Infant Toddler Early Intervention Program (ITEIP) on behalf of the Department of Social and Health Services, the federally designated Lead Agency for Washington State.61

**Waivers**

There are five waivers that the State DDD utilizes:

- Basic Waiver
- Basic Plus Waiver
- Core Waiver
- Community Protection (CP) Waiver
- Children’s Intensive In-home Behavioral Support (CIIBS) Waiver

Each waiver is authorized under CMS Section 1915(b) and funded through the Medicaid program. They share many similarities in the services and assistance offered, but are targeted at different populations. Each waiver is described in detail below using the original description from the waiver application with only slight wording modifications for easier reading.62

**Basic Waiver**

To provide personal care, respite, habilitation, environmental modifications, transportation, specialized medical equipment and supplies, physical therapy (PT), occupational therapy (OT), skills for healthy living (SHL), community access, community guides, person to person assistance, behavior management, family training and emergency assistance to

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individuals who are developmentally disabled (DD) and live with their families or in their own home.

**Basic Plus Waiver**

To provide personal care, respite, habilitation (supported employment), environmental modification, skilled nursing, transportation, specialized medical equipment & supplies, adult residential care, adult foster care, PT, OT, SHL, behavior management, specialized psychiatric services, community access, community guides, person to person assistance, family training and emergency assistance to individuals who are DD and live with their families or in another setting with assistance.

**Core Waiver**

To provide personal care, respite, habilitation (residential, day and supported employment), environmental modification, skilled nursing, transportation, specialized medical equipment & supplies, PT, OT, SHL, behavior management, and family training to individuals who are DD and need residential services or live at home but are at high risk of out-of-home placement.

**CP Waiver**

To provide respite, habilitation (residential, day and supported employment), environ mods., skilled nursing, transportation, specialized medical equipment and supplies, PT, OT, SHL, behavior management, and family training to individuals who are DD and need on-site, awake, 24 hour supervision.

**CIIBS Waiver**

Provides personal care, respite, OT, PT, speech/hearing/language, assisted technology, behavior management/consultation, environmental accessibility adaptations, nurse delegation,
sexual deviancy evaluation, specialized clothing, specialized medical equipment and supplies, specialized nutrition, specialized psychiatric services, staff/family consultation/training, therapeutic equipment and supplies, transportation and vehicle modification for individuals w/DD ages 8-20.

Funding for DDD

Of the $9.8 billion budget of DSHS, $1.9 billion is dedicated to DDD, representing almost 20% of the DSHS budget in 2009.63 Below is a breakdown of DDD funding:

<table>
<thead>
<tr>
<th>Name</th>
<th>Total Funding</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td>$1.442 billion</td>
<td>75.9%</td>
</tr>
<tr>
<td>Institutional Services</td>
<td>$357 million</td>
<td>18.8%</td>
</tr>
<tr>
<td>Eligibility/Case Management</td>
<td>$96.9 million</td>
<td>5.1%</td>
</tr>
<tr>
<td>Administration</td>
<td>$3.8 million</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Community and Institutional services makeup the largest portion of the budget. This is where the actual service delivery takes place in the form of personal care, respite, habilitation, etc. Eligibility and case management (strictly a state function) is next with a little over 5-percent of the budget. Administration, which takes up a negligible amount of the budget, includes budgeting, accounting, contracts, and rate setting for all ADSA services, including DDD.

Role of County

Up to this point, the discussion has centered on the state without mentioning the role of counties, specifically King County in administering and delivery of services for the DD population. According to the county:

“The State DDD is responsible for determining eligibility and authorizing paid services. State DDD currently provides the following services and programs: case management, Medicaid Personal Care, residential services, residential habilitation centers, family support, dental, mental health, Voluntary Placement Foster Care program, and the Medically Intensive program. State DDD administers services on a regional basis. Region 4 is the State DDD office that serves King County.

The King County Developmental Disabilities Division (County DDD) is responsible for providing employment and day program services. County DDD currently provides the following services: Early Intervention/birth-to-three, employment, community access, housing, in-home family counseling, social and recreational activities, information and assistance, advocacy, homelessness projects, and program development/technical assistance.”

The King County DDD exists within the King County Department of Community and Human Services and is operated on a budget of just over $26 million in 2008. This represented approximately 7-percent of the department’s total budget. Within the $26 million allocated to the County DDD, 89-percent of it is from State and Federal grants with the rest coming from local property taxes.

According to Jane Campbell, Assistant Director for the King County DDD, most of the administrative services of the State DDD services are subcontracted to each individual county via each region. This is done not only because the counties have established training and knowledge in the administration of the waiver programs, but also because “it's hard to build on community resources from a distance.”

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64 King County DDD FAQ's Accessed at [http://www.kingcounty.gov/healthservices/DDD/faq.aspx](http://www.kingcounty.gov/healthservices/DDD/faq.aspx) on 11/24/09
A rough flow chart would look something like this:

- Washington State Department of Social and Health Services
- Aging and Disability Services Administration
- State DDD
- King County DDD
- King County Community and Health Services
Wisconsin

The Community Options Program Waiver (COP) was initially implemented in 1982 in select counties. By 1986, it had expanded statewide. In January of 1987, Wisconsin received approval of the COP-waiver request from the federal government, permitting the use of federal Medicaid funds to finance services provided to eligible persons in the community, as an institutional alternative. The COP-waiver provides medical assistance funding for home and community-based care for elderly and individuals with physical disabilities who have long term care needs and who would otherwise be eligible for Medical Assistance reimbursement in a nursing home. State funds are matched by Medicaid dollars to support the COP-waiver program at a ratio of about 40:60. The purpose of COP is to provide cost-effective care alternatives to expensive care in institutions or nursing homes. The County provides a “care manager” to the individual requesting assistance. This care manager knows what services are available in the community and can assist in procuring these services. The care manager also interviews the client or their family in order to learn what families and friends are able to do to assist the client.

Regardless of age or type of disability, anyone requesting the services of a care manager will get an initial Community Options assessment and care plan. There are no income limitations in place to receive these first reviews with a care manager. Income guidelines and initial assessments are used to determine if Community Options will pay for part or all of the

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cost of services. Because the funding available is limited, all other sources of funding or voluntary help are considered before COP waivers are used to pay for services. There are a variety of services provided through COP waiver.

These all are assessed by the County care manager to determine what can be done on a voluntary basis by families or friends and what the program can provide based on the client’s income guidelines.

The initial assessment will answer basic questions about the client’s current health, what they need to take care of themselves daily, their strengths, and how they prefer to live and use the resources available. After the assessment is completed, the care manager works with the client to develop a care plan. This plan encompasses what the client would like to do for themselves, how each of their needs will be met, who will provide the services; including when, where, for how long, and at what cost.

Wisconsin’s waiver programs have been successful in relocating and diverting people from nursing facilities to live in community based settings. In state fiscal year 2008, 895 elderly individuals who, would have otherwise resided in intermediate care facilities for the mentally retarded (ICFs-MR) or nursing facilities, were able to receive the care they required in community based settings. This diversion for institutionalization has saved the State of Wisconsin $4 million in SFY 2008 through the Medical Assistance Program. That is to say that $4 million less was spent on these programs than what would have been budgeted for institutional care.

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According to 1998 financial data, COP and COP-waiver funding totaled $128,356,034\textsuperscript{70}. Of that, funding allocated to COP-waiver amounted to $64,873,224 with the State’s general purpose revenue (GPR) making up 40-percent and Medicaid (MA) making up the remainder. The funds for the COP-waiver program are budgeted by adding a number of “slots” for a given year. Currently, COP-waiver “slots” are funded at $730 per month. These “slots” do not represent individuals served; rather, a slot can be used to serve more than one person. Additional money is budgeted for the administration of this program to cover the costs of care plans, consumer assessments, and administrative and quality assurance activities. In a ten year period, spanning from January 1989 to January 1999, the number of slots allocated to the COP-waiver program increased from 1,076 to 9,840\textsuperscript{71}. As of calendar year 2007, COP and home and community-based waiver programs served a total of 28,430 citizens. Highlighting the savings to the State of the COP-waiver program, the average daily cost of care for participants in the COP-waiver was $75.37, compared to the average daily cost of care for people in nursing homes with the same combination of levels of care was $111.79\textsuperscript{72}.

Similar to Minnesota, the Department of Health Services of Wisconsin administers COP and COP-waiver while the programs are managed by county agencies. Funds are allocated to counties based on the Community Aids formula or for special needs, such as nursing home relocations or to address waiting lists\textsuperscript{73}. The Community Aids formula provides the base allocation. The total amount allocated to the Community Aids formula in calendar year 2010 is

\textsuperscript{72}“Report to the Legislature: Community Options Program Waiver”. Department of Health Services, Division of Long Term Care, Bureau of Long Term Support. Calendar Year 2007. Page ii.
\textsuperscript{73}“Report to the Legislature: Community Options Program Waiver”. Department of Health Services, Division of Long Term Care, Bureau of Long Term Support. Calendar Year 2007. Page 1.
Both COP and COP-waiver provide complementary funding to enable the arrangement of comprehensive services for people in their own homes based on the values of consumer direction and preference. The local Community Options Program Plan describes local resource coordination of the county policies and practices, and assures the cost-effective operation of the program. Each county COP Plan is updated annually with approval by the local Long-Term Support Planning Committee. State level program management monitors local compliance with federal and state program requirements.

**Administration**

Information provided in the aforementioned paragraph describes multiple key players in the administration of COP and COP-waiver programs. The County Board of Supervisors is charged with creating a Long-Term Support Planning Committee. Members of this committee are appointed by the County Board of Supervisors. This committee is responsible for approving each county’s COP Plan when updated.

The Long-Term Support Planning Committee consists of at least five members. These members must either be receiving long-term community support services or be a relative/guardian of a person receiving these services. Additionally, the committee must include:

- At least two elected county officials
- At least one representative from the county health department
- At least one representative from the county department of social services
- At least one representative from the county community departments
- At least one representative from the county commission on aging
- In counties that have a human service department, at least one representative from that agency

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It has been recommended that additional members be represented such as persons who work at local nursing homes, physicians, etc. This committee must develop and approve the COP Plan as well as its annual update. Members of the committee must also develop plans and requirements for quality assurance. Most importantly, the committee must ensure coordination of COP and the Medicaid waivers in ways that maximize the dollars spent.

The county department of social services or human services is the lead agency when administering the COP or COP-waiver program. When both exist within a county, they act as joint lead agencies to administer the programs. These joint lead agencies shall consolidate their activities into a single Community Options Plan. Joint agencies are responsible for:

- Organizing assessment activities
- Coordinating involvement in the assessment process
- Arranging service contracts
- Ensuring that community services are used and COP is used as funding of last resort
- Providing ongoing care management, periodic care plan review, and follow-up services
- Applying the Community Options Uniform Eligibility and Cost-Sharing Plan
- Applying the current program to nursing home residents
- Coordinating the COP and COP-waiver programs with other programs and service systems
- Ensuring program reporting, billing and budget reconciliation
- Implementing quality assurance procedures

Among other responsibilities, the joint committee maintains the continued success of administering the COP and COP-waiver programs.

**Funding**

Currently, the county department repays lead agencies for allowable Community Options expenditures. Assessments and care plans are reimbursed at a flat unit rate determined by the department. If actual expenditures by the county for an individual assessment or care plan are less than the amount reimbursed, the county may retain the reimbursed amount provided the
excess funds are expended for other Community Options purposes. Such funds received by the county may be expended during the calendar year in which they were earned; they may be used only for assessments, care plans, services or administrative costs in the COP, COP-waiver or CIP II programs. Assessments are reimbursed at rates determined by a department specified time study, up to a maximum amount, while care plans are reimbursed at a flat rate. Services, on the other hand, are reimbursed at actual cost, within the MA guidelines. Subcontractors may be paid at rates established by the lead agency within the department’s Allowable Cost Policy.

Transfer of funds from assessments and care plans to a county’s service allocation is allowed. This is allowed under the condition that the county reasonably projects the funds transferred would otherwise remain unspent at the end of the year. Any, or all of such funds which have been transferred may be returned to the assessment and care plan allocation later in the year. Funds allocated for services may not be transferred to the assessment or care plan allocation.

No more than seven percent of service funds may be used for program administration. This can be waived if a variance is granted by the department. The expenses associated with the Interagency Long-Term Support Planning Committee members may be reimbursed as an administrative expense.

At least 20-percent of the agency’s COP and COP-waiver recipients at any point in time must be “high cost” participants. “High cost” participants are defined as those whose “total cost” of community care is greater than twice the allowable cost average. The department shall establish this limit and communicate it to counties annually in the state/county contract. Counties with COP and COP-waiver service caseloads of fewer than 25 people on December 31 of the previous calendar year are exempt from this requirement. “Total cost” of care may
include room and board, COP funds, MA waiver funds, community aids, and Title III; it does not include services which are paid by the person’s Medicaid card.

Current funding rates for calendar year 2009 are as follows:\(^7_6\):

- Assessments at the flat rate of $147 or the individual county established rate, whichever is less
- Care plans at the flat rate of $184 or at the actual cost of time involved to complete each plan
- Maximum allowable average COP service cost for a lead agency is $1,516.02 per month
- “High Cost” participants average $3,783.42 per month
- Maximum staff to participant ratio is 125%

Recommendations

Overarching

- Continually updating all stakeholders.
  - The state of Minnesota has plans for waiver program. It would be beneficial to communicate that information to counties and the general public better whether through newsletters using AARP lists, or postings in community centers. Electronic information easily available online is a good inexpensive way to widely distribute information.
    - Newly designed Hennepin County website makes it easier to get information

- Update computer systems for state and county agencies, the following criteria:
  - Shared between State and County database accessible by all authorized individuals
  - Government contract bid; highly competitive to minimize cost for commercial software that addresses HIPPA privacy concerns
  - Comprehensive database for storing records
  - Database that will not be obsolete

- Leverage granting opportunities for pilot and demonstration projects.
  - There are many people and organizations interested in elderly and disabled services. Non-profits and foundations have money to grant to help create efficiency and improve services to these populations.
    - McKnight Foundation, Robert Wood Johnson Foundation
    - Federal grants from ARRA or CMS (section 1115)

- Make amendment to waiver program.
  - These waiver programs offer an opportunity to make amendments or change the details of the programs. The county could request amendment to CMS waiver application to include funding for assessments.
  - Amend the statues included in H.F. 1362, Section 8, to address a funding mechanism for assessments

- Hennepin County as one region
  - There is a push for regional centers throughout Minnesota. If this becomes a mandate, our recommendation is Hennepin County be one region. Part of this recommendation comes because Hennepin County is the most populated portion of the state.
  - We recommend that the regions proportionally reflect the population.


State-Specific

- California
  - Create Task Forces and pilot projects using funding from grants and other non-traditional funding sources. The purpose of these projects should be to engage stakeholders in a dialogue about service priority as well as enhance service delivery and assessment.

- Erie County, New York
  - Apply for federal demonstration projects focused on the improved cost-efficiencies of acute and long-term care, as well as implementation of technologies such as electronic medical records

- Ohio
  - Contract with a statewide case management agency to provide the necessary case management services for recipients of the HCBS programs.
  - State can negotiate the best rate possible with a contract affecting all counties.

- King County, Washington
  - Moving to a regional system, as opposed to a county-based system, Hennepin County would be a region unto itself. Depending upon the number of regions established by the State, Hennepin County could have two regions contained within its borders.
  - Establish a metric comparing county and state funding of the waiver program to examine efficiency and future cost projections.

- Wisconsin
  - Assessments and care plans are reimbursed at a flat unit rate determined by the county department of social services or human services. In Hennepin County’s case, it would be determined by HSPHD.
  - County budgets for no more than seven-percent of service funds to be used for program administration.
  - If actual expenditures by the county for an individual assessment or care plan are less than the amount reimbursed, the county may retain the reimbursed amount provided the excess funds are expended for other HCBS waiver purposes.
Appendices

Guide to Acronyms

ACT—Access and Coordination Team
ADSA—Aging and Disability Services Administration
BCSP—Ohio Bureau of Community Services Policy
BLTC—Bureau of Long Term Care
CAMMIS—California Medicaid Management Information System
CASA—Community Alternative Systems Agency
CDA—California Department of Aging
DDD—Division of Developmental Disabilities
CDJFS—County Department of Job and Family Services
CDPAP—Consumer Directed Personal Attendant Program
CM—Care Management
CMS—Centers for Medicaid and Medicare Services
COP—Community Options Program, Wisconsin
DOH—Department of Health
DSHP—Department of Social Health Program
DSHS—Department of Social & Human Services
EDS—Electronic Data Systems
FFP—Federal Funding Plan
F-SHRP—Federal-State Human Reform Partnership
GPR—General Purpose Revenue
HCBS—Home and Community-Based Services
HSPHD—Hennepin County’s Human Services and Public Health Department
ICF-MR—Intermediate Care Facility for the Mentally Retarded
IHSS—California
ITEIP—Infant Toddler Early Intervention Program
LTHHCP—Long-term Home Health Care Program
MA—Medicaid
MR/DD—Ohio Department of Mental Retardation and Developmental Disabilities, currently
ODDD at the state level but still functioning as MR/DD at the county level
MSSP—Multipurpose Senior Services Program
NE—Nurse Evaluator
NASHP—National Academy for State Health Policy
NHTD—Nursing Home Transition and Diversion Waiver
ODA—Ohio Department of Aging
ODDD—Ohio Department of Developmental Disabilities, formerly the Ohio Department of
Mentally Retarded and Developmental Disabilities
ODJFS—Ohio Department of Job and Family Services
OHCDS—Organized Health Care Delivery System
OHCW—Ohio Home Care Waiver
OMIG—Office of the Medicaid Inspector General
PAA—PASSPORT Administrative Agency
PHSP—Prepaid Health Services Plan
QMS—Quality Management Specialist
RFP—Request for Proposal
RHC—Residential Habilitation Center
RRDC—Regional Resource Development Center
RRDS—Regional Resource Development Specialists
SNP—Special Needs Plans
SOLA—State-Operated Living Alternatives
Memo’s

To: Kathryn Lamp, Health and Human Services  
From: Humphrey Institute Capstone Group  
Date: December 10, 2009  
RE: California

The state of California and its associated Counties face major budget restrictions in the coming years. In order to deal with a doubling of the senior population over the next 3 decades, departments, agencies, and service providers must find innovate ways to serve senior and disabled populations.

Two initiatives within the State of California highlight what local governments can do to ensure sufficient service delivery while preserving funds for administrative purposes.

**Seamless Senior Services (S3)**

The S3 Task Force intends to “enhance service delivery and improve coordination between departments” for seniors. After a stakeholder meetings and analysis of different programs, the key points were:
- Integration of services allow for improved identification, and service delivery for senior and adults with disabilities
- Each county had a stated mission and vision statements that guided them
- Counties leveraged resources to develop greater efficiencies
- Allowed for input on behalf of constituents and stakeholders during planning and implementation
- Allowed for greater collaboration between services for innovated service delivery

**Network of Care**

The Network of Care is a comprehensive website dedicated to disseminating information to seniors about the availability of care, news updates, and legislative news. It's considered a one-stop information tool allowing seniors to keep personal records, create an online family meeting place, and communicate directly with elected officials to make their voice heard in the legislative halls.

Network of Care was sponsored by a CDA innovation grant in partnership with the Alameda County Department of Aging and Adult Services. The project is part of a broad effort to improve and better coordinate long-term care services in our community.
To: Kathryn Lamp, Health and Human Services  
From: Humphrey Institute Capstone Group  
Date: December 10, 2009  
RE: New York (Erie County)  

The New York State Department of Health (DOH) manages several waivers in the State of New York along with specialized departments such as the New York State Office for the Aging and Bureau of Long Term Care (BLTC). Counties are responsible for the assessment and coordination of Medicaid benefits and waiver programs for county citizens.

The two waiver programs offered to seniors in New York are the New York Nursing Home Transition and Diversion Waiver (NHTD) and the New York Federal-State Health Reform Partnership (F-SHRP). The purpose of the NHTD waiver is to provide a community alternative to individuals eligible for placement in a nursing home in order to avoid the high costs that are associated with such care.

F-SHRP is a federal demonstration project focused on the improved cost-efficiencies of acute and long-term care as well as implementation of technologies such as electronic medical records. One of the goals of F-SHRP is to shift emphasis from institutional to community-based care in order to achieve cost savings. In FY 2008 over $500 million was saved, well on it's way to a goal of $3 billion by the end of the demonstration in 2011.

In Erie County, the administrative cost per dollar of benefit cost is $0.024 but does not include assessments of Medicaid-eligible individuals. It does however provide a comparison to current costs within Hennepin County HSPHD.
To: Kathryn Lamp, Health and Human Services  
From: Humphrey Institute Capstone Group  
Date: December 10, 2009  
RE: Ohio

The Ohio Department of Job and Family Services (ODJFS) provides funding for and is ultimately responsible for all eight waivers within Ohio Medicaid. Although ODJFS provides the funding for all CMS waivers, it only administers three of them. The other waivers are administered by the Ohio Department of Developmentally Disabled (ODDD) and the Ohio Department of Aging (ODA).

ODJFS contracts with a case management agency, CareStar, to provide the necessary case management services for recipients of the home- and community-based waiver programs. Monitoring compliance of the waiver programs, ODJFS conducts comprehensive quality assurance programs. It should be noted that CareStar is under contract with ODJFS to serve all 88 counties through four regional offices.

With the forthcoming changes, Hennepin County will be mandated rate changes. The State should contract with one case management agency to ensure common rate-setting by the January 2011 timeline that has been set forth. By having companies compete for the state contract, the best rate will be negotiated.
To: Kathryn Lamp, Health and Human Services  
From: Humphrey Institute Capstone Group  
Date: December 10, 2009  
RE: Washington (King County)

Washington State utilizes a region-based approach to the delivery and administration of human services. There are six different regions that aim to be similar in size and demand for services. King County, Washington's largest county and home to almost 30% of its population, acts as its own region.

There are five waivers available for eligible adults with DD in the state of Washington, differing in that some are targeted at specific age ranges and others focus on at-risk populations. The services provided are mostly the same, providing personal care, habilitation, PT, and OT among other resources.

This region-based system asks the state to provide case management, personal care, residential services, along with a few other services. The county is tasked to provide employment, community access, housing, and program developments. The total budget for King County DDD was approximately $26 million in FY 2008 while the state budget was $1.9 billion. The ratio of county funding vs. state funding per dollar of state funding in 2008 was $0.014. To put it another way, for every dollar budgeted by the state, the county budgeted $0.014 for DD services.

According to Jane Campbell, Assistant Director of King County Developmental Disabilities Division, King County is subcontracted via its region to perform most of the state services as they had the infrastructure setup to do so, and in her words “allows for more local and community-building relationships.”
Wisconsin’s Community Options Program Waiver (COP) was initially implemented in 1982 in select counties and was statewide by 1986. Services are coordinated from the State level, with funding, to the local Long-Term Support Planning Committee. The Committee is charged with developing and approving the COP Plan; annual updates to the Plan; develop plans and requirements for quality assurance; and ensure coordination of COP and the Medicaid waivers in ways that maximize the dollars spent. The county department of social services or human services is the lead agency when administering the COP program.

Assessments and care plans are reimbursed at a flat unit rate determined by the county department of social services or human services, depending on the county. If actual expenditures by the county for an individual assessment or care plan are less than the amount reimbursed, the county may retain the reimbursed amount provided the excess funds are expended for other Community Options purposes. Services, on the other hand, are reimbursed at actual cost, within the MA guidelines. Subcontractors may be paid at rates established by the lead agency within the department’s Allowable Cost Policy.

As the County’s role shifts from case management to administration, funding will be questioned. Wisconsin budgets for no more than seven percent of service funds to be used for program administration. This can be waived if the county’s social service or human services department grants a variance. By building in the administration reimbursement in the funding formula, counties can ensure payment for their coordination service.
Informational Documents

Home and Community Based Waiver Program Changes

**Home and Community Based Waiver Programs:**
A) Changing Roles and Responsibilities
B) Financing County Administrative Support

**Outcomes and Expectations**

<table>
<thead>
<tr>
<th>Federal CMS</th>
<th>MN Dept Human Services</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Clients have access to HCBS services and supports in their communities statewide</td>
<td><strong>A.</strong> There is a comprehensive assessment tool</td>
<td><strong>A.</strong> Identify gaps; develop necessary services and qualified providers for HCBS services</td>
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<tr>
<td><strong>B.</strong> Clients have choice of case manager</td>
<td><strong>B.</strong> There is a standardized menu of service options</td>
<td><strong>B.</strong> Determine eligibility for financial and service or HCBS program eligibility; includes necessary assessments</td>
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<tr>
<td><strong>C.</strong> There is a statewide rate methodology that is cost effective and reduces geographic variations</td>
<td><strong>C.</strong> There is a standardized service plan format</td>
<td><strong>C.</strong> Information is available about resource and service options</td>
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<tr>
<td><strong>D.</strong> There are consistent standards and applications for quality assurance statewide.</td>
<td><strong>D.</strong> “Qualified Provider” is defined</td>
<td><strong>D.</strong> Maintain eligibility and avoid breaks in coverage</td>
</tr>
<tr>
<td><strong>E.</strong> Individuals have information about HCBS services that is readily available and they can make application</td>
<td><strong>E.</strong> There are case management performance standards</td>
<td><strong>E.</strong> Manage program resource allocation</td>
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<td><strong>F.</strong> Intake and Eligibility is completed timely</td>
<td><strong>F.</strong> Training and support for case management</td>
<td><strong>F.</strong> Provide local oversight; assure county residents that providers and programs meet contract and regulatory standards</td>
</tr>
<tr>
<td><strong>G.</strong> Clients are safe and secure in their homes and communities, taking into account their information and expressed choices</td>
<td><strong>G.</strong> Administration is streamlined</td>
<td></td>
</tr>
</tbody>
</table>
standards and expectations

Organization Chart

Aging and Disability Services
Human Services and Public Health Department

Todd Monson
Area Director

Sarah Maxwell
Acting Area Director

Sharlene Shelton
Area Manager

Vacant
Area Manager

Katie Patterson
Program Manager

Kathy Rogers
Program Manager

Katie Chamberlin
Program Manager

Jadieh O'Connell
Program Manager

Elena Grant
Seniors Planning Analyst

Nancy Chilson
Managed Care for Seniors

Jamel Walker
Managed Care for Seniors

Natalie Rosen
HPR Team

Claudia Gibson
HPR Team

Karen Marks
HPR Team

Lynnea Bently
HPR Team

Christine Mehta
HPR Team

Susan Sharkey
HPR Team

Carole Dorazio
Managed Care for Seniors

Jana Aiba
Financial Management

Jason Wilson
LTCM - Adults

Annette Fitch
LTCM - Adults

Bill Yelich
LTCM - Adults

Theresa Servon
LTCM - Children

Chuck Moore
LTCM - Children

Jean Gabrielson
LTCM - Children

Virginia Wehner
LTCM - Adults

Carol Jed
Aide - Adults

Polly Keen
Aide - Children

Brooke Karter
Aide - Adults

Susan Felt
Aide - Adults

Nancy Grant-Larsen
Aide - Adults

Dawn Knafl
Aide - Adults

Patti Spinley
Registration Project

Toni Fuller
Aide - Adults

Budged FTEs 403.4

*As of 09/30/2020. FTEDs may not reflect the exact number on the SDH report.
Continuing Care Fact Sheet

Fast Facts: 2009 Legislative Session

Changes affecting continuing care services

The 2009 Legislature and executive action, including unallotment, resulted in changes to services for aging Minnesota and people with disabilities. These changes sustain long-term care programs, reform personal care assistance services, promote consistency and help balance the state budget.

Sustainability

- **Nursing home level of care criteria.** A new law, effective Jan. 1, 2011, redirects people with lower care needs to other supports, while ensuring continued access to nursing facility level of care for people with the greatest long-term care needs by increasing the level of need required for nursing facility level of care.

- **Essential Community Services grant.** People who will no longer qualify for nursing facility level of care may qualify for the soon-to-be established Essential Community Services grant, which will provide emergency and assistance call devices, caregiver support and education, homemaker, chore services and service coordination depending on their need.

- **Corporate foster care moratorium.** July 1, 2009, a moratorium begins on initial licenses for child and adult corporate foster care with exceptions for settings that meet criteria identified by DHS.

- **Elderly Waiver customized living services.** For clients with 0 or 1 dependency in qualified activities of daily living, their monthly budget limit is the lower of their current budget limit or that in effect Oct. 1, 2008. Current recipients are subject to the limit when reassessed in fiscal year 2010.

- **Communities for a Lifetime.** By Feb. 28, 2010, the Minnesota Board on Aging must recommend to the Legislature a process and criteria for communities to request and receive the designation of Community for a Lifetime and finding sources to implement these communities.

Personal care assistance reform

- **Effective July 1, 2009,** all personal care assistance agencies are required to enroll or re-enroll with the state and assure that they meet provider standards and are qualified to provide services. Standards include a training requirement. A personal care attendant (PCA) will be paid for a maximum of 275 hours a month regardless of the number of agencies or individuals worked for.

- **As of Jan. 1, 2010,** all recipients must have PCAs supervised by a qualified professional, the process of assessing and authorizing services will be simplified and made more consistent, and a person must be dependent in at least one activity of daily living or have a level 1 behavior to be eligible for services.

- **DHS, in consultation with stakeholders,** is to develop alternatives to PCA services for individuals with mental health and other behavioral challenges who can benefit from services that more appropriately meet their needs and assist them in living independently in the community. A report to the Legislature is due Jan. 15, 2011, with implementation plans by July 1, 2011.

www.dhs.state.mn.us
Elderly Waiver Program

What is the Elderly Waiver Program?

The Elderly Waiver (EW) program funds home- and community-based services for people age 65 and older who are eligible for Medical Assistance (MA) and require the level of care provided in a nursing home, but choose to reside in the community. The Minnesota Department of Human Services operates the EW program under a federal waiver to Minnesota’s Medicaid State Plan. Counties, tribal entities and health plan partners administer the program.

What types of services are available?

Covered services include:
- Adult day care
- Chore services
- Companion services
- Consumer-directed community supports
- Home health aides
- Home-delivered meals
- Homemaker services
- Licensed community residential services (customized living services or 24-hour customized living services, family foster care, residential care)
- Environmental accessibility adaptations
- Personal care assistant
- Respite care
- Skilled nursing
- Specialized equipment and supplies
- Training for informal caregivers
- Transitional supports
- Transportation

Who is eligible?

- Those eligible for the Elderly Waiver program are 65 or older, eligible for Medical Assistance and need nursing home level of care as determined by the Long-Term Care Consultation process.
- The EW service cost for an individual cannot be greater than the estimated nursing home cost for that same individual.

How many people? How many dollars?

In fiscal year (FY) 2008, the Elderly Waiver program served 24,319* recipients through fee-for-service (FFS) and managed care options (Minnesota Senior Health Option or MSHO and Minnesota Senior Care Plus-MSC+). The total dollars spent on waiver services was $256,208,194**.

www.dhs.state.mn.us
Timeline Changes

- January 2009
  - Start of pilot program
  - Initial planning
- February 2009
  - Pilot program expansion
  - Additional funding secured
- April 2009
  - Full implementation
  - Evaluation of pilot program
- June 2009
  - Phase 2 planning
  - Additional resources allocated
- July 2009
  - Implementation of new programs
  - Initial evaluations conducted
- September 2009
  - Final adjustments made
  - Program evaluation completed
- October 2009
  - Final report submitted
  - Program assessment conducted

Timeline Implementation Timelines

2009 Continuing Care Administration

- April 2009
  - Project initiation
  - Funding secured
- May 2009
  - Planning and design
  - Staff training commencement
- June 2009
  - Implementation begins
  - Initial assessments conducted
- July 2009
  - Full implementation
  - Evaluation initiated
- August 2009
  - Final adjustments
  - Program evaluation
- September 2009
  - Final report
  - Program assessment
- October 2009
  - Program closure
  - Post-implementation review

Care Continuum

- Toyota
  - Referral process
  - Initial assessment
- June 2009
  - Initial visit
  - Cumulative care plan developed
- July 2009
  - Continuing care plan
  - Follow-up assessments
- August 2009
  - Final adjustments
  - Program evaluation
- September 2009
  - Final report
  - Program assessment
- October 2009
  - Program closure
  - Post-implementation review
2009 Continuing Care Administration Legislation Implementation Timeline

May 2009
- Disaster provisions take effect

July 2009
- Begin Corporate Foster Care (CFC) Moratorium
- Foster care 5% of 95th percentile reduction
- Limit growth in CADI and TBI waivers
- 5-bed foster care licenses available in specific situations
- Implement independent center AC and EW individual caps for all new admissions
- Implement service rate limits for 24-hour customized living
- Begin development of the comprehensive assessment system
- Begin LTC certified assessor curriculum development
- Long-term option counseling
- Begin PCA and home care reform implementation
- PCA factor set at $2080 for nursing facility bed closures
- Provider rate and grant reductions

October 2009
- MA payment for single beds reduced to 11.5%
- Increase built ten rate for privatized facilities

April 2010
- Implement return to community initiative

January 2010
- Statewide waiver priorities established
- Limit growth in DD waivers
- Implement rate-setting customized living tools statewide for EW services
- Implement training-certified LTC assessment
- Begin screening for new PCA access - Phase I (IADL or Level 1 Behavior)
- PCA Report

July 2010
- Background study required for all waiver services (open federal proposal for CDHS)
- Complete implementation of new PCA access - Phase I

Dec. 2010
- Housing Options due report to the Legislature

January 2011
- Begin phase-in of the common rate-setting structure for waiver services
- Report on CFC licensing moratorium, including use of technology
- Residential Support Service license proposed statutory language and implementation plan
- Implement ADL criteria for new customized living 24-hour payment
- Implement essential community supports
- Begin phase-in of assessments by the certified LTC assessors
- Begin phase-in of COMPASS
- Alternative to PCA report
- PCA Report
- Begin new NT-LTC criteria

July 2011
- GRH transfer to the DD waiver
- Begin new PCA access (2 ADLs) – Phase II
- Begin implementation of PCA alternative
- Award delayed CSDD grants

October 2011
- APS inflation for nursing facilities suspended

January 2012
- Single set of standards report due to the Legislature

October 2012
- APS inflation for nursing facilities suspended

Waivers and Alternative Care
- COMPASS and assessments
- PCA and Home Care
- Nursing Facilities
- Across many areas