



Paul R. LePage, Governor

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January 26, 2012

To: Senator Richard Rosen, Senate Chair
 Representative Patrick Flood, House Chair,
 Members of the Joint Standing Committee on Appropriations and Financial Affairs

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: Part II - DHHS response to questions from the January 12th, 13th and 18th Work Sessions.

January 12th Work Session

Targeted Case Management

1. Rep. Flood: Regarding TCM for homeless- does that impact domestic violence shelters and if so, how much?

Response: We were not able to assess the impact to domestic violence shelters but we have provided below information regarding Targeted Case Management that falls within the homeless population.

Total Dollars to T1017_U5 Homeless Population

Mandatory Rate Codes Only

Rate Code Claim (Multiple Items)

Row Labels	STATE TOTAL	FEDERAL TOTAL	TOTAL Expenditures
T1017-U5	300,225.36	590,150.62	890,375.98
Grand Total	300225.36	590150.62	890,375.98

Unduplicated Members Mandatory Rate Codes

Rate Code Claim (Multiple Items)

Duplicate

Member ORIGINAL

Row Labels	Count of Person ID Unencrypted
T1017-U5	852
Grand Total	852

Unduplicated Members ALL Rate Codes

Rate Code Claim (All)

Duplicate

Member ORIGINAL

Row Labels	Count of Person ID Unencrypted
T1017-U5	1,103.00
Grand Total	1103

Adult Family Care

2. Rep. Webster: Would like a “historical look-back”, given that a number of programs such as this were put in place to reduce costs, that spells out the “tiering” of levels of care and the total costs for each year.

Response:

Over the last several decades, Maine has initiated reforms to reduce its reliance on institutional long term care and to offer affordable and less restrictive choices for consumers and their families. In the 1990s, Maine initiated several reforms, including the targeting of nursing home admissions to those most in need by raising the medical eligibility threshold. Maine’s Legislature established a law requiring that anyone seeking admission to a nursing facility, regardless of payment source, be assessed for medical eligibility based on a standardized assessment conducted by an independent assessing agency. As a result of these reforms, between 1995 and 1998, Maine saw a reduction in nursing facility spending of 15%. Although expenditures for home and community based care increased (both in dollar amounts and as a percent of total long term care spending), this increase was offset by the savings in the nursing facility account. Total Medicaid and State funded long term care expenditures declined by 7% during 1995-1998 whereas the number of individuals receiving services increased 19%.

As part of this strategy, less costly community options were developed as alternatives to nursing facility care, including the residential care facilities now known as PNMLs, and adult family care homes. These settings were intended to provide supportive living but in a less restrictive, and more home like setting than nursing facilities. Initially in the 1990's, considerable resources were allocated to market this option and to provide technical assistance to those interested in establishing an adult family care home. These resources are no longer available.

Currently, there are 31 adult family care homes in 8 counties, primarily found in the more rural areas of the state. Size is limited to 8 or fewer beds and the medical/functional eligibility assessment is conducted by the provider. Current reimbursement ranges from \$23.84 to \$71.68 per resident per day depending on care required based on the MDS-ALS.

An overview on service use trends is included as part of the “Chartbook Report -Older Adults and Adults with Disabilities: Population and Service Use Trends in Maine” at the following link: <http://www.maine.gov/dhhs/oes/publications.htm#chartbook>. Specifically, see Appendix A, Table A-4 on Page

January 13th Work Session

Hospital Reimbursements

3. Rep. Flood: What is the status of debt to the hospitals?

Response:

Due Hospital SY 2011 & SY 2012					
1	Due to Hospital - Crossovers through 2011		48,129,103		
2	Due to Hospital - Settlements through 2011		529,530,563	Estimated Dollars	
3	Total	Sum of lines 1 & 2	577,659,666		
4	Paid Hospitals in SY 2011		247,175,091		
5	Net Due Hospital as of 6/30/11	Lines 3 minus line 4	330,484,574	Estimated Dollars	
6	Due to Hospital - Updates for Drafts/Revisions/Appeals through 2011		21,081,473	Estimated Dollars	
7	Due to Hospital - Crossovers through 2012		34,231,033		
8	Due to Hospital - Settlements through 2012		74,727,654	Estimated Dollars	
9	Net Due Hospital as of 6/30/12	Sum of lines 5 -8	460,524,735		

4. Rep Rotundo: Would like a 10-year history of PIP payments (Table 1) and hospital settlements (Table 2).

Response:

Table 1

Calendar Year	PIP
2003	\$ 205,954,269
2004	\$ 262,469,438
2005	\$ 297,520,019
2006	\$ 341,091,450
2007	\$ 364,814,625
2008	\$ 432,180,923
2009	\$ 407,878,001
2010	\$ 390,930,864

Table 2

Summary Hospital Settlements Paid SY 2002-2011				
	# of Settlements	Total Paid	State Dollars	Federal Dollars
State Year 2002	28	1,741,328	639,590	1,101,738
State Year 2003	15	6,789,196	2,493,672	4,295,524
State Year 2004	85	82,931,646	30,460,794	52,470,852
State Year 2005	21	66,525,776	24,434,918	42,090,859
State Year 2006	20	*132,263,354	49,069,704	83,193,650
State Year 2007	36	101,000,452	37,097,466	63,902,986
State Year 2008	17	22,565,386	8,279,240	14,286,146
State Year 2009	204	263,989,674	70,287,251	193,702,423
State Year 2010	101	144,873,057	36,421,087	108,451,970
State Year 2011	144	247,175,089	66,801,540	180,373,550
Total Paid to Hospitals SY 2002-2011	671	1,069,854,958	325,985,260	743,869,698
*SY 06 Includes Appeal Agreement of \$96M				

5. Sen. Rosen: DHHS will add Critical Access to the answer to Question #12 on January 3rd.

Response: The quantifiable impact to Maine Hospitals by Initiative. Not reflected below are non-quantifiable impacts to the hospitals due to the reduction/elimination of other services or eligibility categories.

Initiative #	Initiative Name	SFY12 Total	SFY13 Total
7481	Hospital Outpatient Reduction - 5%		(8,537,635)
7467	Hospital Outpatient Limit	(758,306)	(3,973,729)
7488	Hospital Inpatient Rate Reduction	(2,867,137)	(8,395,720)
7468	Hospital Inpatient Limit	(251,066)	(1,315,654)
7464	Critical Access Reduction from 109% to 105%	(794,628)	(3,167,259)
Total Quantifiable Impact to Hospitals		(4,671,137)	(25,389,997)

Developmental Disabilities

6. Senator Katz - How does the section 21 waiver money get allocated, initially? In other words, who sets the limit of how much money we can spend on the section 21 waiver program? Is the service limited by the Legislative appropriation?

Response: The section 21 comprehensive Waiver has been in place since the early 1980s. The Waiver was implemented by the Reagan administration as an alternative to institutional care in an ICF/MR. An individual with intellectual disabilities must be eligible for institutional care in order to qualify for the Waiver and he/she must “waive” placement in an ICF/MR.

CMS requires that the cost of Waiver support must not exceed the cost which would be incurred if the people served were institutionalized. The Department files annual cost reports to CMS to verify that costs are below the cap (the average cost of care in an ICF/MR). It must also report on the total number of people it plans to serve in the coming year.

Money for the seed comes from the General Fund and from an Other Special Revenue account whose funds are generated by a service provider tax on a number of services provided under the Waiver. Thus, the number of recipients is limited by the Legislative appropriation.

7. What behaviors, challenges and needs do the individuals, in the top 5% of waiver cost, have? Provide a description.

Response: The following description is a client that is being served at a rate of \$1,060.08 per day. Individual is a male with a diagnosis of Autism and moderate mental retardation. He communicates verbally using two or three word sentences. He shows emotion through behavior, sometimes yelling, throwing objects, or self-injurious behaviors. Swings in mood can occur rapidly and without warning. He needs support staff with him at all times for health and safety reasons and 2:1 staffing is needed when he is in the community. Verbal prompting is needed to complete all activities of daily living. This individual needs constant staff to keep himself and the community safe. Constant supervision is also required because the individual does not react to pain and can easily injure himself. This individual has a history of hitting and injuring staff. Client requires restraint at times because his incidences of aggression are unpredictable and can prove to be life-threatening to others.

8. What are the criteria for determining medical add-on's? What do these people have for needs compared to the rest of waiver members? Provide a description.

Response: The term ‘Medical add-on’ is a reference to an enhanced home support, work support or community support rate, for those individuals that have specialized medical needs. The medical add-on rate is higher than the standard rate for these services. An individual qualifies for a medical add-on based on the assumption that the persons medical needs require specially trained staff and nursing/clinical oversight.

Clinical oversight and duties may include: (This is an actual case)

- RN observes and intervenes in any changes in skin integrity.
- RN assesses and provides ongoing training and monitoring to staff regarding dysphasia.
- RN assesses and provides ongoing training and monitoring to staff for risk of injury due to falling due to spasticity.
- RN assesses monitors and provides on-going training to staff on transfer procedures due to impaired physical mobility.
- RN assesses monitors and provides on-going training to staff on special dietary needs.
- RN monitors a BM sheet and maintains a bowel protocol for client needs.
- RN is the liaison between the residential home and the health care providers in order to coordinate the care for client's complex medical needs.
- RN monitors and trains staff on daily stretching routine as well as physical therapy exercises.
- RN assesses monitors and provides on-going training to staff on client's self-care deficits.

9. What is the history of other rental subsidy reductions?

Response: Prior to SFY'08, OACPD-ADS utilized a portion of its General Fund allocation to fund this subsidy. In SFY'08, the 123rd Legislature, via Public Law, Chapter 240, enacted an "Initiative: Provides funding for room and board costs for approximately 2,000 individuals." \$4 million was allocated for (SFY'08) and a matching amount for SFY 2008-2009. In SFY'09 an initiative reduced this amount by \$220,000 due to a social security income cost-of-living increase (Chapter 1, Section A-1, page 77). In SFY'10, an initiative reduced this funding by (\$479,682) with a like amount of reduction occurring in SFY'11 (Section A-31, Page 308).

10. What is the justification for using the HUD value?

Response: The OACPDS is seeking to standardize the process of applying for and awarding rental subsidy funds. The goal is to fairly and equitably allocate these resources in a manner that will allow for necessary reimbursement to providers and will allow for potential fiscal savings.

The Department of Housing and Urban Development publishes Fair Market Rates, which are defensible and relevant to the residences that we subsidize.

11. What is the background on the management of the waiver?

Response: Please see question and answer #6. Additionally, the State of Maine currently views section 21 waiver as having an aggregate cap on spending. This view is different than the other State waivers, as they manage waiver spending as an individual cap. CMS requires that the cost of Waiver support must not exceed the cost which would be incurred if the people served were institutionalized. The Department files annual cost reports to CMS to verify that costs are below the cap (the average cost of care in an ICF/MR). It must also report on the total number of people it plans to serve in the coming year.

The OACPDS is proposing to change the section 21 spending to an individual cap to align this waiver with the others. OACPDS is also proposing to cap new waiver participants at the institutional rate (\$161,000 per year) in an effort to limit individual cost and serve more individuals with the allocated funds.

For additional information related to CMS- see **Attachment A** - Olmstead Letter No. 4.

12. What is the amount of current spending on the percentage of those adults in need of waiver services?

Response: The section 21 waiver program currently has a total of 597 individuals on the waitlist. Of these 597 individuals: 225 are on priority #1, 235 are on priority #2 and 137 on priority #3.

The section 29 waiver program currently has a total of 333 individuals on the waitlist. The average cost of a section 21 waiver member is \$100,939. The average cost of a section 29 waiver member is \$21,732.

Individuals have been on the waitlist for an extended period of time and their changing needs are unknown. OACPDS does not currently track the costs associated with each individual on the waitlist, due to this fluctuation of need. However, we do ask for an update of the individuals needs when it's determined that there are funds available to add members to the waiver.

13. Provide more background on the proposed reductions.

Response: The OACPDS is seeking reductions in services in order to address our waitlist. We want to serve individuals that are waiting for services by streamlining and standardizing our current service structure. DHHS has identified reductions that we feel could be sustained. A 10% reduction to Group Home Support rate and the elimination of medical add-on could provide approximately \$10 million dollars to use toward those waiting for services.

14. What is the opportunity to use the additional savings to reduce the waitlist?

Response: Please see question and answer # 13.

15. What are the details on the wait lists for each waiver?

Response: Please see questions and answer # 12. Additionally, below is a description of the determination of priority levels for the section 21 waiver.

Priority 1: Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 et seq., and if the member continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

Priority 2: Any member on the waiting list shall be identified as Priority 2 if the member has been determined to be at risk for abuse in the absence of the provision of benefit services identified in his or her service plan. Examples of members who shall be considered Priority 2 include:

1. A member whose parents have reached age sixty (60) and are having difficulty providing the necessary supports to the member in the family home; or
2. A member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

Priority 3: Any member on the waiting list shall be identified as Priority 3 if the member is not at risk of abuse in the absence of the provision of the benefit identified in the service plan. Examples of members who shall be considered Priority 3 include:

1. A member living with family, who has expressed a desire to move out of the family home;
2. A member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation;
3. A member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the member; or
4. A member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.

See Attachment B for additional information regarding Developmental Disability Services.

January 18th Work Session

16. What is the definition of a disability? How is a person identified as disable? Is it when they can no longer work?

Response:

Any impairment could potentially be disabling, if it imposed enough of a functional limitation. Many factors play in to the decision, the claimant's age, education, past work experience, as well as the impairment or combination of impairments. Some conditions are more straightforward to assess; certain types of cancer, cognitive disability, paralysis, blindness, but these cases cannot be processed on diagnosis alone. Even with these impairments, significant supporting material is needed.

The Social Security disability determination process takes about 100 days from the time the claimant goes to the SSA field office to the time they get a decision. If the individual appeals a decision, the first level of appeal would take an additional 70 days or so. The next level past that would take about an additional year. The next level after that can take an additional several months.

17. Can we get the number of people on MaineCare that have SSI and SSDI income? Can we break out the disabilities that they have? Also, break out the age groups?

Response:

As of January 19, 2012, the total number of persons enrolled in MaineCare who have a favorable MRT decision but do NOT receive SSI or SSDI income equals 7,346.

The age breakdown of this group is as follows:

Less than age 21:	812
Between ages 21 and 30:	1,206
Between ages 31 and 40:	1,191
Between ages 41 and 50:	1,295
Between ages 51 and 60:	1,179
Between ages 61 and 64:	474
Between ages 65 and 74:	1,169

The current (as of January 19, 2012) total number of people enrolled in MaineCare who receive SSI or SSDI income equals 66,784.

The age breakdown is as follows:

Under 21:	5,488
Between 21 and 30:	6,194
Between 31 and 40:	8,800
Between 41 and 50:	14,723
Between 51 and 60:	18,582
Between 61 and 64:	6,570
Between 65 and 74:	4,181
Greater than or equal to 75:	2,246

Greater than or equal to age 75: 20

18. If a member is diagnosed with a life threatening illness (say Cancer) at age 17/18 and we eliminate coverage for 19/20 year olds is there a way to cover this individual who has since lost coverage but has this life threatening illness?

Response: There is no catastrophic illness coverage group in Maine. The individual would likely be reviewed for eligibility based on disability and would potentially remain eligible.

For a definition of "disabled" please see question #16.

Cc: Governor Paul R. LePage
Dan Billings, Chief Counsel, Governor's Office
Kathleen Newman, Deputy Chief of Staff, Governor's Office
Katrinn Teel, Senior Health Policy Advisor, Governor's Office
Peter Rogers, Director of Communications, Governor's Office
Sawin Millett, Commissioner, Department of Administrative and Financial Services (DAFS)
Dawna Lopatosky, State Budget Officer, DAFS
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

SMDL #01-006

Olmstead Update No: 4

Subject: HCFA Update

Date: January 10, 2001

Dear State Medicaid Director:

This is the fourth in a series of letters designed to provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA). In attachments to this letter, we address certain issues related to allowable limits in home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act.

In attachments to this letter, we address certain questions related to State discretion in the design and operation of HCBS waivers under section 1915(c) of the Social Security Act. We also explain some of the principles and considerations that the Health Care Financing Administration (HCFA) will apply in the review of waiver requests and waiver amendments. Finally, we respond to key questions that have arisen in the course of State or constituency deliberations to improve the adequacy and availability of home and community-based services, or recent court decisions.

We encourage you to continue forwarding your policy-related questions and recommendations to the ADA/Olmstead workgroup through e-mail at ADA/Olmstead@hcfa.gov.

HCFA documents relevant to Medicaid and the ADA are posted on the ADA/Olmstead website at <http://www.hcfa.gov/medicaid/olmstead/olmshome.htm>.

Sincerely,

Timothy M. Westmoreland
Director

Enclosures

Attachment 4-A "Allowable Limits and State Options in HCBS waivers"

Attachment 4-B "EPSDT and HCBS waivers"

State Medicaid Director – 2

cc:

HCFA Regional Administrators

HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
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National Association of State Medicaid Directors

Joy Wilson
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Virginia Dize
Director, State Community Care Programs
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Attachment 4-A

Subject: Allowable Limits and State Options in HCBS Waivers

Date: January 10, 2001

In this attachment, we discuss limits that States may place on the number of persons served and on services provided under an HCBS waiver. Current law requires States to identify the total number of people who may be served in an HCBS waiver in any year. States may derive this overall enrollment limit from the amount of funding the legislature has appropriated. However, once individuals are enrolled in the waiver, the State may not cap or limit the number of enrolled waiver participants who may receive a covered waiver service that has been found necessary by an assessment.

We have received a number of questions regarding limits that States may, or are required to, establish in HCBS waivers under section 1915(c) of the Social Security Act. Many of these questions have arisen in the course of discussions about the ADA and the Supreme Court Olmstead decision. Others have arisen in the context of certain court cases premised on Medicaid law. Examples include:

1. ***Overall Number of Participants:*** May a State establish a limit on the total number of people who may receive services under an HCBS waiver?
2. ***Fiscal Appropriation:*** May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?
3. ***Access to Services Within a Waiver:*** May a State have different service packages within a waiver? Once a person is enrolled in an HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?
4. ***Sufficiency of Amount, Duration, and Scope of Services:*** What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?
5. ***Amendments that Lower the Potential Number of Participants:*** May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?
6. ***Establishing Targeting Criteria for Waivers:*** How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

In subjects 1 and 2, we explain current law and policy regarding the setting of limits on the total number of people who may be eligible for an HCBS waiver. In subject 3, we provide new clarification with respect to the access that waiver enrollees must be afforded within a waiver, consistent with recent court decisions. In subject 4, we explain that, while section 1915(c) permits a waiver of many Medicaid requirements, the requirement for adequate amount, duration, and scope is not waived. In subject 5, we discuss special considerations that HCFA will apply when reviewing any waiver amendment request in which the total number of eligible individuals would be reduced, so that the implications of the proposed amendment are fully addressed in light of all applicable legal considerations. In subject 6, we seek to reduce State administrative expenses by permitting States to develop a single waiver for people who have a disability or set of conditions that cross over more than one current waiver category.

The answers to the questions below are derived from Medicaid law. However, because Medicaid HCBS waivers affect the ability of States to use Medicaid to fulfill their obligations under the ADA and other statutes, we have included these answers as an Olmstead/ADA update.

1. Overall Number of Participants

May a State establish a limit on the total number of people who may receive services under an HCBS waiver?

Yes. Under 42 CFR 441.303(f)(6), States are required to specify the number of unduplicated recipients to be served under HCBS waivers:

The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment.

Thus, unlike Medicaid State plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. If other laws (e.g., ADA) require the State to serve more people, the State may do so using non-Medicaid funds or may request an increase in the number of people permitted under the HCBS waiver. Whether the State chooses to avail itself of possible Federal funding is a matter of the State's discretion. Failure to seek or secure Federal Medicaid funding does not generally relieve the State of an obligation that might be derived from other legislative sources (beyond Medicaid), such as the ADA.

If a State finds that it is likely to exceed the number of approved participants, it may request a waiver

amendment at any time during the waiver year. Waiver amendments may be retroactive to the first day of the waiver year in which the request was submitted.

2. Fiscal Appropriation

May a State use the program's funding appropriation to specify the total number of people eligible for an HCBS waiver?

HCFA has allowed States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by HCFA (the approved "factor C" value), or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match). The current HCBS waiver pre-print used by States to apply for waivers contains both options. States sometimes use the second option because of the need to seek Federal waiver approval prior to the appropriation process, and sometimes the legislative appropriations are less than the amount originally anticipated. In addition, the rate of turnover and the average cost per enrollee may turn out to be different than planned, thereby affecting the total number of people who may be served.

In establishing the maximum number of persons to be served in the waiver, the State may furnish, as part of a waiver application, a schedule by which the number of persons served will be accepted into the waiver. The Medicaid agency must inform HCFA in writing of any limit that is subsequently derived from a fiscal appropriation, and supply the calculations by which the number or limit on the number of persons to be served was determined. This information will be considered a notification to HCFA rather than a formal amendment to the waiver if it does not substantially change the character of the approved waiver program. If a State fails to report this limit, HCFA will expect the State to serve the number of unduplicated recipients specified in the approved waiver estimates.

3. Access to Services Within a Waiver

May a State have different service packages within a waiver? Once a person is enrolled in a HCBS waiver, can the individual be denied a needed service that is covered by the waiver based on a State limit on the number of enrollees permitted access to different waiver services?

No. A State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. Thus, the State cannot develop separate and distinct service packages for waiver population subgroups within a single waiver. The opportunity for access pertains to all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.

This does not mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may impose reasonable and appropriate limits or utilization

control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

This clarification does mean, however, that States are not allowed to place a cap on the number of enrollees who may receive a particular service within the waiver. There is no authority provided under law or regulation for States to impose a cap on the number of people who may use a waiver service that is lower than the total number of people permitted in the waiver. Denial of a needed and covered service within a waiver would have the practical effect of: (a) undermining an assessment of need, (b) countermanding a plan of care/support based on such an assessment of need, (c) converting a feasible service into one that arbitrarily benefits some waiver participants but not others who may have an equal or greater need, and (d) jeopardizing an individual's health or welfare in some cases.

Similarly, a State may not limit access to a covered waiver service simply because the spending for such a service category is more than the amount anticipated in the budget. In the same way that nursing facilities may not deny nursing or laundry services to a resident simply because the nursing or laundry expenses for the year have exceeded projections, the HCBS waiver cannot limit access to services within the waiver based on the budget for a specific waiver-covered service. It is only the overall budget amount for the waiver that may be used to derive the total number of people the State will serve in the waiver. Once in the waiver, an enrolled individual enjoys protection against arbitrary acts or inappropriate restrictions, and the State assumes an obligation to assure the individual's health and welfare.

We appreciate that a State's ability to provide timely access to particular services within the waiver may be constrained by supply of providers, or similar factors. Therefore, the promptness with which a State must provide a needed and covered waiver service must be governed by a test of reasonableness. The urgency of an individual's need, the health and welfare concerns of the individual, the nature of the services required, the potential need to increase the supply of providers, the availability of similar or alternative services, and similar variables merit consideration in such a test of reasonableness. The complexity of "reasonable promptness" issues may be particularly evident when a change of living arrangement is required. Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate." Where the need for a change of living arrangement for a particular person is clear but not urgent, application of the reasonableness test to determine "reasonable promptness" could provide more time.

We recognize the question of reasonable promptness is a difficult one. We wish to call the issue to your attention as a matter of considerable importance that merits your immediate review. The issue will receive more attention from us in the future and is already receiving attention by the courts. The essential message is that the State's ability to deliver on what it has promised is very important. During CY 2001, we expect to work closely with States to improve our common understanding of what reasonable promptness requires. We also hope to collaborate with you on the infrastructure

improvements that States may need to improve local ability to provide quality, customer-responsive and adequate services or supports in a timely manner.

4. Sufficiency of Amount, Duration and Scope of Services

What principles will HCFA apply in reviewing limitations that States maintain with respect to waiver services?

Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

In exercising discretion to approve new waiver requests, we will apply the same sufficiency concept to the entire waiver itself, i.e., whether the amount, duration and scope of all the services offered through the waiver (together with the State's Medicaid plan and other services available to waiver enrollees) is sufficient to achieve the purpose of the waiver to serve as a community alternative to institutionalization and assure the health and welfare of the individuals who enroll.

In applying this principle, it is not our intent to imply or establish minimum standards for the number or type of services that must be in an HCBS waiver. Because the waiver wraps around Medicaid State plan services, and because the needs of each target group vary considerably, it is clear that the sufficiency question may only be answered by a three-way review of (a) the needs of the selected target group, (b) the services available to that target group under the Medicaid State plan and other relevant entitlement programs, and (c) the type and extent of HCBS waiver services. Whether the combination of these factors would permit the waiver to meet its purpose, particularly its statutory purpose to serve as a community alternative to institutionalization, is an analysis we would expect each State to conduct.

Where a waiver design is manifestly incapable of serving as such an alternative for a preponderance of the State's selected target group, we would expect the State to make the adjustments necessary to remedy the problem in its waiver application for any new waiver. In other cases, an exceptionally limited service design may prevent an existing waiver from being able to assure the health or welfare of the individuals enrolled. Where, subsequent to a HCFA review of quality in an existing waiver, it is very clear that the waiver design renders it manifestly incapable of responding effectively to serious threats to the health or welfare of waiver enrollees, we would expect the State to make the necessary design adjustments to enable the State to fulfill its assurance to protect health and welfare. The fact that States have the authority to limit the total number of people who may enroll in a waiver provides States with reasonable methods to control the overall spending. This means that States should be able to manage their waiver budgets without undermining the waiver purpose or quality by exceptional restrictions applied to services that will be available within the waiver.

5. Amendments That Lower the Potential Number of Participants

May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

A State may amend an approved waiver to lower the number of potential eligibles, subject to certain limitations. The following represent special considerations that HCFA will take into account in reviewing such waiver amendments:

Existing Court Cases or Civil Rights Complaints: If the number of waiver eligibles is a material item to any ongoing legal proceeding, investigation, finding, settlement, or similar circumstance, we will expect the State to (a) notify HCFA and the court of the State's request for a waiver amendment, and (b) notify HCFA and the DHHS Office for Civil Rights whenever a waiver amendment is relevant to the investigation or resolution of any pending civil rights complaint of which the State is aware.

Avoiding or Minimizing Adverse Effects on Current Participants: Under section 1915(c)(2)(A), HCFA is required to assure that the State has safeguards to protect the health and welfare of individuals provided services under a waiver. Thus, a key consideration in HCFA's review of requests to lower the number of unduplicated recipients for an existing waiver is the potential impact on the current waiver population. By "current waiver population," we refer to people who have been found eligible and have enrolled in the waiver. Any reduction in the number of potential waiver eligibles must be accomplished in a manner that continues to assure the health, welfare, and rights of all individuals already enrolled in the waiver. An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA. The State may address these concerns in several ways:

- ❖ The State may provide an assurance that, if the waiver request is approved, the State will have sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the amendment.
- ❖ The State may assure HCFA that no individuals currently served on the waiver will be removed from the program or institutionalized inappropriately due to the amendment. For example, the State may achieve a reduction through natural attrition.
- ❖ The State may provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the proposed amendment. For example, a State that no longer requires its waiver, because it has added as a State plan

service the principal service(s) provided by the waiver, may specify a method of transitioning waiver participants to the State plan service. We note that any individual who is subject to removal from a waiver is entitled to a fair hearing under Medicaid law, and the methodology of transition is particularly important in that context.

- ❖ The State may provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or significant loss of services. We anticipate that this may occur when a State seeks to consolidate two or more smaller waivers into one larger program.

This discussion should not be construed as limiting a State's responsibilities to provide services to qualified individuals with disabilities in the most integrated settings appropriate to their needs as required by the ADA or other Federal or State law.

6. Establishing Targeting Criteria for Waivers

How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?

Under 42 CFR 441.301(b)(6), HCBS waivers must "be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill." States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

HCFA recognizes that discrete target groups may encompass more than one of the categories of individuals defined in this regulation. For example, persons with acquired brain injury may be categorized as either physically disabled in accordance with section 441.301(b)(6)(i) or developmentally disabled in accordance with section 441.301(b)(6)(ii) depending on the age of the person when the brain injury occurred. In such cases, HCFA will permit the State to have one waiver to serve the defined target population that could conceivably encompass more than one category of the regulations in order to avoid the unnecessary administrative expense resulting from the development of a second waiver for the target population.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Attachment 4-B

Subject: EPSDT and HCBS Waivers

Date: January 10, 2001

In this attachment, we clarify ways in which Medicaid HCBS waivers and the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services interact to ensure that children receive the full complement of services they may need.

States may take advantage of Medicaid HCBS waivers under section 1915(c) of the Social Security Act to supplement the services otherwise available to children under Medicaid, or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, States must ensure that (1) all children, including the children made eligible for Medicaid through their enrollment in a HCBS waiver, receive the EPSDT services they need, and (2) children receive all medically necessary Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid, and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under an approved HCBS waiver.

Included in the Social Security Act at section 1905(r), EPSDT services are designed to serve a twofold purpose. First, they serve as Medicaid's well-child program, providing regular screenings, immunizations and primary care services. The goal is to assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly. Under federal EPSDT rules, States must provide for periodic medical, vision, hearing and dental screens. An EPSDT medical screen must include a comprehensive health and developmental history, including a physical and mental health assessment; a comprehensive unclothed physical examination; appropriate immunizations; laboratory tests, including lead blood level assessments appropriate for age and risk factors; and health education, including anticipatory guidance.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to

diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law

Medicaid's HCBS waiver program serves as the statutory alternative to institutional care. This program allows States to provide home or community-based services (other than room and board) as an alternative to Medicaid-funded long term care in a nursing facility, intermediate care facility for the mentally retarded, or hospital.

- Under an HCBS waiver, States may provide services that are not otherwise available under the Medicaid statute. These may include homemaker, habilitation, and other services approved by HCFA that are cost-effective and necessary to prevent institutionalization. Waivers also may provide services designed to assist individuals to live and participate in their communities, such as prevocational and supported employment services and supported living services. HCBS waivers may also be used to provide respite care (either at home or in an out-of-home setting) to allow family members some relief from the strain of caregiving.
- In addition, under a Medicaid HCBS waiver, a State may provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income of a spouse or parent. This is accomplished through a waiver of section 1902(a)(10)(C)(i)(III) of the Social Security Act, regarding income and resource rules.

In all instances, HCBS waivers supplement but do not supplant a State's obligation to provide EPSDT services. A child who is enrolled in an HCBS waiver also must be assured EPSDT screening and treatment services. The waiver is used to provide services that are in addition to those available through EPSDT.

There are a number of distinctions between EPSDT services and HCBS waivers. While States may limit the number of participants under an HCBS waiver, they may *not* limit the number of eligible children who may receive EPSDT services. Thus, children cannot be put on waiting lists for Medicaid-coverable EPSDT services. While States may limit the services provided under an HCBS waiver in the ways discussed in attachment 4-A, States may *not* limit medically necessary services needed by a child who is eligible for EPSDT that otherwise could be covered under Medicaid. Children who are enrolled in the HCBS waiver must also be afforded access to the full panoply of EPSDT services. Moreover, under EPSDT, there is an explicit obligation to "make available a variety of individual and group providers qualified and willing to provide EPSDT services" 42 CFR 441.61(b).

Similarly, a State may use an HCBS waiver to extend Medicaid eligibility to children who otherwise would be eligible for Medicaid only if they were institutionalized. Such children are also entitled to the full complement of EPSDT services. Children made eligible for Medicaid through their enrollment in an HCBS waiver cannot be limited to the receipt of waiver services alone.

The combination of EPSDT and HCBS waiver services can allow children with special health care, as well as developmental and behavioral needs, to remain in their own homes and communities and receive the supports and services they need. The child and family can benefit most when the State coordinates its Medicaid benefits with special education programs in such a way as to enable the family to experience one system centered around the needs of the child. In developing systems to address the needs of children with disabilities, we encourage you to involve parents and other family members as full partners in your planning and oversight activities. HCFA staff will be pleased to consult with States that are working to structure children's programs around the particular needs of children with disabilities and their families.

Please refer any questions concerning this attachment to Mary Jean Duckett (410) 786-3294.

Fact Sheet- Current as of December 2011
OACPDS- Developmental Services
01/23/2012

<u>Waiver Service</u>	<u>Total Commitment</u>	<u>Client Count</u>
Section 29	\$28,926,410.04	1331
Section 21	\$285,155,019.75	2825

Section 29**

<u>Average</u>	<u>Client Count</u>	<u>Service</u>
\$21,732.84	1331	Overall Section 29 Waiver Average
\$20,631.96	1306	Community Support
\$6,034.05	295	Work Support

**Section 29 also includes: Employment Specialist Services (Job Development) and Home Accessibility Adaptations Services.

Section 21**

<u>Average</u>	<u>Client Count</u>	<u>Service</u>
\$100,939.83	2825	Overall Section 21 Waiver Average
\$20,302.21	1943	Community Support Average
\$8,865.71	624	Work Support Average
\$129,000	1538	Group Home Support Average (Only Group Home Services)
\$94,019.37	2409	Total Home Support Average (All Home Support Services, including Group)
\$44,069.37	372	Home Support Hourly Average (1/4 hr only)
\$9,071.92	311	All Other Therapy Consultation Average

**Section 21 also includes: Employment Specialist Services (Job Development), Home Accessibility Adaptations, Specialized Medical Equipment/ Supplies, Communication Aids/ Consultation/ Assessment, Consultation Services, Counseling, Crisis Services, OT, PT, Speech.

Waitlist

<u>Waiver Service</u>	<u>Client Count</u>			
Section 29	333			
Section 21	Priority 1- 225*	Priority 2- 235**	Priority 3- 137***	

*Priority 1: has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 et seq.

**Priority 2: has been determined to be at risk for abuse in the absence of the provision of benefit services identified in his or her service plan. Examples of members who shall be considered Priority 2 include: 1. a member whose parents have reached age sixty (60) and are having difficulty providing the necessary supports to the member in the family home; or 2. a member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

***Priority 3: not at risk of abuse in the absence of the provision of the benefit identified in the service plan. Examples of members who shall be considered Priority 3 include: 1. a member living with family, who has expressed a desire to move out of the family home; 2. a member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation; 3. a member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the member; or 4. A member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.

Rates

<u>Service</u>	<u>Section 29</u>	<u>Section 21</u>
Community Support	\$5.28 per ¼ hour.	\$5.28 per ¼ hour.
Work Support	\$6.91 per ¼ hour.	\$6.91 per ¼ hour.
Intermittent Home Support (1/4 hr)	----	\$6.27 per ¼ hour.
Shift Staffing Home Support (Group)	----	\$23.61 per hour.
Shared Living Home Support	----	\$126.19 per day—One Person*
Family Centered Home Support	----	\$104.17 per day—One Person*

*Shared Living and Family Centered Home Support Services rates change depending on the number of persons living in the home.

Proposed Reductions
OACPDS- Developmental Services
01/23/2012

1. 10% rate Reduction to Section 21 Group Home Support.

- Shift staffed, group home programs account for 70% of all authorized funding in Section 21.
- The current annualized approved authorizations for this service is \$199,000,000.
- A 10% cut will reduce group home funding by \$19.9 million. The average group home service cost will reduce to approximately \$116,000 per person.
- \$19.9 million reduction represents \$12.59 million of Federal money and \$7.3 million State money.

2. Elimination of Medical Add-on.

- Medical add-ons are currently costing \$2.7 million dollars, under section 21 and section 29 waivers.
- Eliminating this service would save \$991,710 state funds and \$1,708,290 federal funds.

3. Individual service cap of 100% of the institutional rate or \$161,000 for Section 21 waiver.

- Individuals currently on the waiver program would be “grandfathered”—not subject to this rule change.
- There would be no immediate fiscal savings; however it’s expected that long term DHHS would save funds by limiting the annual spending that is allowed by new individuals.

Summary: FY13

<u>Proposed Reduction/ Change</u>	<u>State \$</u>	<u>Federal \$</u>	<u>Total</u>
10% rate reduction	\$7,300,000.00	\$12,590,000.00	Approx. \$19.9 million
Elimination Med Add on	\$991,710.00	\$1,708,290	\$2.7 million
Individual Cap	-----	-----	-----

Totals: **\$8,291,710.00** **\$14,298,290.00** **\$22,600,000.00**

Totals (After contributing \$3 million to general fund deficit):

\$5,291,710.00 **\$9,115,341.00** **\$14,407,051.00**

Reinvestment of saved funds into waitlist:

-Using the above formulas and totals, DHHS would have \$14,407,051.00 to reinvest into the section 21 waitlist. If using the \$161,000 institutional rate per year, DHHS could potentially serve about 89 individuals with these savings.

Representative Martin’s Question:

-DHHS’ current proposals in regard to Developmental Services do not jeopardize work support or employment services. Individuals on section 21 and section 29 waivers are eligible for 1125 hrs/yr of community support and 850 hrs/yr of work support services, when used separately.

-If DHHS begins to implement the individual annual cap of \$161,000 per year/ per member, than individuals would need to take into account all of their service spending to remain under the limit.