KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Health Policy Oversight

November 5, 2010

Home and Community Based Services Waivers

&

Potential Impact of Federal Health Care Reform

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Chairwoman Landwehr and members of the Committee, thank you for the opportunity to appear before you today. I am Ray Dalton, Deputy Secretary of Disability & Behavioral Health Services at the Kansas Department of Social and Rehabilitation Services. Today I will present information regarding six Home and Community Based Service Waivers that provide services to persons with disabilities, including the number of individuals served and funding for each of the programs. I have included a chart with more detail on the waivers in Attachment A. In addition, I will briefly address the potential impact of the federal Patient Protection and Affordable Care Act as it relates to the Medicaid services managed by SRS.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and assistive services, are not covered by the regular federal Medicaid program. HCBS waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Centers for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

Developmental Disability (DD) Waiver

The DD waiver serves individuals with significant developmental disabilities. As of October 1, 2010, there are 2,334 people on the waiting list receiving no waiver services, and another 989 people receiving some services who are waiting for additional services. In FY 2010 there were 295 individuals who left waiver services. These

positions were filled by individuals in crisis situations. SRS maintains one statewide waiting list for HCBS-DD services which includes both the unserved and the underserved. A person's position on the waiting list is determined by the request date for the service(s) for which the person is waiting. Each fiscal year, if funding is made available, people on the statewide waiting list are served, beginning with the oldest request dates at the top of the list. An additional $3.3 million SGF was allocated to the DD waiver for FY 2011. SRS is in the process of working with the Community Developmental Disability Organizations to offer services to individuals on the waiting list. It was originally estimated that at least 145 individuals will be served with this funding. Because the average cost of the people on the top of the waiting list had a lower cost per person than the people currently on the waiting list, 214 people have been offered and accepted services.

During FY 2010, $311,275,693 was paid through the DD waiver to serve an average of 7669 people a month.

On January 1, 2010 and on February 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- On January 1, 2010, Oral Health Services were eliminated.
- On February 1, 2010, Temporary Respite Care services were eliminated.

Physical Disability (PD) Waiver

During FY 2008 the rate of growth in the waiver increased significantly and on December 1, 2008, SRS implemented a waiting list for the PD waiver. The waiting list was implemented not to cut the budget, but to avoid further overspending. With the implementation of a waiting list approximately 7,300 individuals have been able to continue receiving services. In December 2008 when the waiting list was implemented only persons in a crisis situation were allowed to access new waiver services. On March 2, 2009, the "rolling" waiting list methodology was implemented whereby one consumer was offered services for every two terminations. On January 1, 2010, due to the budget situation, the rolling waiting list methodology was terminated and only persons meeting the crisis criteria were allowed to access PD waiver services (the only other opportunity to access these services was through the MFP grant). As of October 1, 2010, there were 2,503 individuals on the PD Waiver waiting list.

The PD waiver received an additional $3.6 million SGF, which we anticipated would allow for the start of a rolling waiting list in October 2010. However, because the expenditure data for the first three months of FY2011 show a decrease in the number of people served but an increase in the average cost per person we have not instituted the rolling waiting list at this time. We are looking deeper into the data and will continue to monitor the expenditures before instituting the rolling waiting list.

During FY 2010, $140,511,242 was paid through the PD waiver to serve an average of 6,964 people per month.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Eliminating Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.

- Limiting assistive services to crisis situations only, with approval by the program manager.
- A change in the crisis criteria was made to eliminate the criteria that a person could enter services if the individual was at significant, imminent risk of serious harm because the primary caregiver(s) were no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s): own disabilities, return to full time employment, hospitalization or placement in an institution, moving out of the area in which the consumer lived, or death.

Traumatic Brain Injury (TBI) Waiver

The TBI waiver is designed to serve individuals who would otherwise require institutionalization in a Head Injury Rehabilitation Hospital. The TBI waiver services are provided at a significant cost savings over institutional care and provide an opportunity for each person to live and work in their home communities. Each of these individuals is provided an opportunity to rebuild their lives through the provision of a combination of supports, therapies and services designed to build independence.

A significant difference in this program is that it is not considered a long term care program. It is considered a rehabilitation program and consumers are expected to transition off the program or to another program upon completion of rehabilitation. Individuals currently receive up to four years of therapy and, if by that time progress in rehabilitation is not seen, the individual is transitioned to another program. In FY 2010 the average length of stay in this program was 1.9 years. This number is based on the consumers who transitioned from services during FY 2010. There is currently no waiting list for this program.

During FY 2010, $13,085,895 was paid through the TBI waiver to serve an average of 323 people per month.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Elimination of Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- Moving third year continuation of service review to program manager as opposed to committee.

Technology Assisted (TA) Waiver

The TA waiver is designed to serve children ages 0 to 22 years who are medically fragile and technology dependent, requiring intense medical care comparable to the level of care provided in a hospital setting, for example, skilled nursing services. The services provided through this waiver are designed to ensure that the child's medical needs are addressed effectively in the child's family home, thereby eliminating the need for long term and or frequent hospitalization for acute care reasons. There is no waiting list for this program. The TA waiver served 483 (unduplicated) children in FY2010 at a total cost of $ 24,594,116 and an average monthly cost per person of $ 5,418.

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Serious Emotional Disturbance (SED) Waiver

The HCBS waiver for youth with a Serious Emotional Disturbance allows federal Medicaid funding for community based mental health services for youth who have an SED and who are at risk of being placed in a state mental health hospital. The SED waiver determines the youth's Medicaid eligibility based on his/her own income separate from that of the family. Once the youth becomes a Medicaid beneficiary he/she may receive the full range of all Medicaid covered services including the full range of community mental health services. In addition, the youth is eligible for specific services only available to youth on the SED Waiver. The services offered through the SED waiver and other community mental health services and supports are critical in assisting the youth to remain successfully in his/her family home and community. During FY 2010, $48,448,927 was paid through the SED waiver to serve a total of 6,021 children.

Autism Waiver

The autism waiver is the newest of our HCBS waivers with the first funding approved for FY 2008. The target population for the autism waiver is children with autism spectrum disorders (ASD), including autism, Aspergers' Syndrome, and other pervasive developmental disorders. The diagnosis must be made by a licensed medical doctor or PhD psychologist using an approved autism specific screening tool. Children are able to enter the program from the age of diagnosis through the age of five. Children receiving services through this waiver would be eligible for placement in a state mental health hospital if services were not provided through the waiver. A child will be eligible to receive waiver services for a time period of three years with an exception process in place to allow children who demonstrate continued improvement to continue services beyond the three year limit.

The autism waiver was implemented on January 1, 2008. At that time 25 children were selected through a random process to receive services. The other applicants were placed on the waiting list. The 2008 Legislature approved funding for an additional 20 children to be served by the autism waiver in FY 2009. The waiver is now serving 45 children. There are 251 children waiting for services through this waiver. Since this waiver was implemented, 166 children have aged off of the waiting list before services could begin. The total expenditure for the waiver in FY2010 was $743,673 with the average monthly cost per person being $1,546.

SRS Fee Fund

Over the past several years SRS fee fund balances have been used to fill the gap between available SGF and waiver spending and the funds allocated for the HCBS Waivers. The fee fund balance has now been depleted and SRS will be $11 million short for FY 2012. SRS will be requesting an enhancement to replace the $11 million shortfall with the next budget submission. SRS's options regarding changes that may be made to fill this gap are limited by federal regulations that have been implemented through the Recovery Act and the Affordable Care Act. These regulations do not allow states to change the waiver eligibility requirements without loss of federal funding. Under the Recovery Act the number of persons served by the waivers may not drop below the number of individuals that were being served on July 1, 2008. The only options that are

available to SRS to control spending are through serious rate reductions and then to evaluate what additional service limitations could be implemented.

Potential Impact of Federal Health Care Reform

Much of the detail regarding requirements for states in implementing the Patient Protection and Affordable Care Act is yet unknown, because regulations have not yet been issued. From what is known so far, we think Kansas is positioned to implement the various provisions the Act. The various state agencies (Kansas Insurance Department, Kansas Health Policy Authority, SRS, KDHE, KDOA) that would be involved with implementation are all assessing the provisions of the Act, are prepared to review regulations as they are issued, and are actively reviewing and applying for grant opportunities under the act as they become available.

Secretary Jordan has established an internal health reform steering committee to ensure we are evaluating the Act and its potential impact on existing SRS programs and processes. SRS is actively tracking federal regulations and regularly reviewing health care reform funding and grant opportunities reported through Federal Funds Information for States (FFIS). Each division of SRS is reviewing and following the Act's provisions as they become applicable, and is reviewing information, reviews and commentary about the Act and its implementation options developed by various program-area experts.

The most significant immediate impact of the Act relates to maintenance of effort requirements associated with HCBS waiver programs in Kansas. Under the Act, the requirement is that states maintain eligibility standards, methodologies and procedures that were in place as of March 23, 2010. This requirement for adults will expire when the state exchange system is operational, except that for populations with income below 133% of poverty, the requirement expires on January 1, 2014 (when all non-elderly non-disabled adults with incomes up to 133% of poverty will become mandatory eligibles). For children, the maintenance of effort requirement is retained until the end of 2019. Unlike the ARRA, which made compliance with its maintenance of effort provision a condition to receiving ***enhanced*** FMAP, compliance with the maintenance of effort provision in the Act is a condition to receiving ***any*** federal financial participation for the program out of compliance, during the period in which the requirement applies.

Additional potential impact, especially in substantial areas related to covered services, will not be known until benefit packages are established. Changes in benefit packages may have a significant impact on Kansas' mental health and substance abuse treatment service programs, which have been designed around the idea of a large number of uninsured individuals needing access to comprehensive behavioral health services. Additional impact on the HCBS waiver programs in Kansas continues to be evaluated, and will depend in part upon how some of the new waiver options under the Act are operationalized. And finally, through our review of the Act thus far, from an SRS perspective, there does not appear to be a need for any statutory changes in conjunction with the various provisions of the Act.

This concludes my testimony; I will stand for questions.

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Attachment A - Overview of Medicaid Home & Community Based Services Waivers Operated by DBHS/CSS

WAIVER	AUTISM	DEVELOPMENTAL DISABILITY	PHYSICAL DISABILITY	TECHNOLOGY ASSISTED	TRAUMATIC BRAIN INJURY	SERIOUSLY EMOTIONALLY DISTURBED (SED)
Institutional Equivalent	State Mental Health Hospital Services	Intermediate Care Facility for Persons with Mental Retardation	Nursing Facility	Acute Care Hospital	Head Injury Rehabilitation Facility	State Mental Health Hospital
Eligibility	➢ Time of diagnosis through 5 years of age ➢ Diagnosis of an Autism Spectrum Disorder or PDD-NOS ➢ Meet functional eligibility ➢ Eligible for State Institutional	➢ Individuals age 5 and up ➢ Meet definition of mental retardation or developmental disability ➢ Eligible for ICF/MR level of care	➢ Individuals age 16-64* ➢ Determined disabled by SSA ➢ Need assistance with the activities of daily living. ➢ Eligible for nursing facility care **Those on the waiver at the time they turn 65 may choose to stay on the waiver*	➢ Children under age 22 ➢ Dependent upon intensive medical technology ➢ Medically fragile ➢ Requires the level of care provided in an acute hospital	➢ Individuals age 16-65 ➢ Have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities ➢ Eligible for in-patient care in a Head Injury Rehabilitation Hospital	➢ Children 4-18; under 4 /over 18 if age exception approved ➢ Choose HCBS ➢ Determined Seriously Emotionally Disturbed by CMHC ➢ Meet admission criteria for State Hospital
Point of Entry	Preliminary Autism Application is sent to the HCBS/Autism Program Manager	Community Developmental Disability Organization	Case management Entities	Case management Entities	Case management Entities	CMHC Staff

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WAIVER	AUTISM	DEVELOPMENTAL DISABILITY	PHYSICAL DISABILITY	TECHNOLOGY ASSISTED	TRAUMATIC BRAIN INJURY	SED
Financial Eligibility Rules	➢ Only the individual's personal income & resources are considered ➢ Parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care
Services/ Supports Additional regular Medicaid services are provided	➢ Consultative Clinical and Therapeutic Services (Autism Specialist) ➢ Intensive Individual Supports ➢ Parent Support/and training ➢ Family Adjustment Counseling ➢ Respite Services ➢ **Functional Eligibility Specialist is a contracted services*	➢ Assistive Services ➢ Day Services ➢ Medical Alert Rental ➢ Sleep Cycle Support ➢ Personal Assistant Services ➢ Residential Supports ➢ Supported Employment ➢ Supportive Home Care ➢ Wellness Monitoring	➢ Personal Services ➢ Assistive Services ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Case Management ➢ Specialized medical care (skilled nursing) ➢ Long term community care attendant ➢ Medical respite ➢ Home modifications	➢ Personal Services ➢ Assistive Services ➢ Rehabilitation Therapies ➢ Transitional Living Skills ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Wraparound Facilitation ➢ Independent Living / Skill Building Services ➢ Parent Support and Training ➢ Short Term Respite Care ➢ Professional Resource Family Care ➢ Attendant Care