

PROPOSED AGENDA
Meeting of MACDDS Medicaid Waiver Group and Department Representatives
Wednesday, May 21, 2008

- A. That State of Wyoming created a rate structure for waiver services that is based on providers' costs, with the assistance of Navigant Consulting. Rates for waiver services are reflective of the average of providers' costs and are inclusive of accreditation and training costs. Clients are assigned a score relative to their level of severity which translates into a plan of needed supports and a corresponding waiver budget. The result is a per client spending limit rather than a single waiver cap. No amendments to existing waivers were necessary to rebase rates and CMS is supportive of a rate setting methodology with a basis in actual costs. Colorado also has a HCBS waiver application pending that utilizes a cost based rate model for certain waiver services. In addition, Colorado contracts with Community Centered Boards, which are 501(c)(3) entities that serve as the single point of entry of services for the developmental disability population. These entities provide TCM and are designated as Organized Health Care Delivery Systems (OHCDS). Dental and vision services not otherwise covered in the Medicaid state plan are included in the waiver.

This concept was initially of interest to the Medicaid Waiver Group because it was a way for providers to recover the costs associated with CARF accreditation and College of Direct Support costs. It is also of interest because Wyoming is analyzing different assessment tools, including the Support Intensity Scale (SIS), which DMH is also investigating.

- B. The concept of a health care home is a recommendation of the Medicaid Transformation Report. The value of the concept is undisputed, but implementation remains a problem because of a lack of financial incentives for primary care providers, lack of staff and knowledge of social service programs in primary care offices and the inability to provide necessary follow up for implementation. A review of the utilization rates of service provision by the managed care companies reveals the difficulties in linking Medicaid eligibles to necessary services. County boards could serve as the link between their clients and a medical home by keeping abreast of applicable periodicity schedules for clients, identifying chronic conditions requiring routine medical management, and performing functions such as scheduling, arranging transportation, appointment reminders with the purpose of increasing preventive care in collaboration with the primary care provider. The State of Iowa has implemented a *1st Five* Healthy Mental Development Initiative that partners private providers with local public health entities. It has been successful in identifying at risk children and increasing referrals for Part C services. Iowa has developed surveillance and screening tools and is reviewing EPSDT codes to determine if currently billable codes are adequately covered.
- C. Two states, Nebraska and Pennsylvania, have been identified as having children's waivers that enhance Medicaid revenue for children in Early Childhood programs. The Nebraska program serves children under 3 years of age who are eligible for the Early Intervention Program. Parental income is disregarded in determining eligibility. Eligible children receive a monthly allowance for respite care and service coordination. Pennsylvania also disregards parental income in determining eligibility for children 0 – 3 years; but children must have a higher level of delay to be eligible for Habilitation services, which is a bundled service that covers a number of waiver services.

D. Federal law and regulation define a Qualified Mental Retardation Professional (QMRP) and provide guidance on when a QMRP is required in the provision of services. Missouri has chosen to require the provision of services by a QMRP in situations in which one is not mandated by federal regulation, thereby increasing providers' costs and limiting the number of staff available to perform the tasks.