Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

To: Elderly Waiver Interim Committee
Fr: Department of Human Services
Re: Follow up information to hearing
Date: December 29, 2008

Patty Funaro, LSA, asked the Department to provide information regarding the following issues.

1. What is being done to reduce documentation duplication?

The documentation rules are currently in the Iowa Administrative Code 441-Chapter 79. In the above rules, Home and Community Based Consumer Directed Attendant Care providers are required to use a form that was developed by DHS (along with input from AFSCME). The reason for requiring the form was due to the findings in audits of CDAC providers, both individuals and agencies. During the audits of CDAC providers it was discovered that approximately 20% have no required documentation and 20% have inadequate documentation. During reviews, it was also discovered that some providers are billing what is authorized in the individual's service plan and not what was provided. As you probably know, documentation is essential to the health, safety and welfare of the individual served along with documenting the service provided and time spent by the provider for billing purposes. It shows what has been done, the time it took, the individual's response and any other issues/observations that may need addressed during service provision. CMS has not changed their requirements for documentation but have and are sending out auditors to look at State Medicaid programs. Therefore, the DHS is being proactive with the development of this form and statewide trainings. Please find attached a copy of the form that is required.

2. What is being done about long-term planning for the needs of seniors including regulation, documentation, shortages of direct care workers and others, etc?

There has been a statewide effort that have been working on the development of a long term plan for Iowa's seniors including:

- Senior Living Coordinating Unit
- 2 Direct Care Worker Workgroup-mandated by the Legislature
- Single Point of Entry Workgroup - mandated by the Legislature
- Nursing Facility Accountability Measure Workgroup – mandated by the Legislature
- Medicaid Quality Improvement Workgroup - mandated by the Legislature

The legislature receives copies of any mandated reports.

3. Are there descriptions of all waivers to compare?

See Attachment (Home and Community Based Services Comparison Chart).

4. Where are we with telehealth?

Telehealth or "telemedicine" is generally defined as the use of telecommunications technology and equipment to link health care practitioners and patients in different locations. Iowa Medicaid conducted a legislatively mandated telemedicine pilot study between 1997 - 2000. Based on the lack of definitive data at the end of the pilot, the Legislature discontinued that pilot program. In the wake of the telemedicine pilot, Iowa Medicaid has not provided payment for telemedicine components (e.g. costs associated with the hardware, software, line charges, or related components associated with telemedicine) that are associated with the provision of otherwise covered services. However, that notwithstanding, Iowa Medicaid will pay for otherwise covered medical services if rendered via telemedicine, ***if*** the standard in the medical community would support rendering those services via telemedicine.

Magellan has a telehealth project for psychiatrists seeing patients via telehealth. Through Community Reinvestment Magellan can fund locations who meet criteria and offer a minimum number of hours of service to Medicaid clients on a monthly basis. Each location is allowed $7670 for the web cam and equipment for sending and receiving images of the doctor and patient. Because these are clients with mental health needs, there is a payment for care coordination at the site with the patient. The care coordinator can monitor medications and make arrangements for other services that the doctor prescribes.

5. Should telemonitoring be a reimbursable service? What would the overall cost be including start-up and maintenance?

There are several types of telehealth or telemonitoring systems available throughout the medical network. An analysis of the different types of systems and costs would need to be completed to provide a complete response.

6. Should windshield time and mileage be reimbursable expenses? What does this add to the cost of doing business?

Windshield time and mileage reimbursement are not considered a billable activity, as the time does not provide a direct service to or on behalf of the Medicaid member. However, it may be considered an allowable cost when establishing the Medicaid rate through administrative expenditures. Therefore, providers may recover their travel costs.

7. Recommendations for addressing the shortage of direct care workers and other providers of services?

House File 2539, known as the Health Care Reform Bill, includes a number of initiatives directed to addressing the shortage of direct care workers. Below is a summary of initiatives relevant to direct care workers:

Direct Care Worker Compensation Advisory Committee (Section 70): The Department of Human Services was required to convene a committee to develop recommendations regarding wages and other compensation paid to direct care workers in nursing facilities. Findings and recommendations were to be submitted to Governor and legislature by December 12. A copy of this report is available.

Direct Care Worker Nursing Facility Turnover Report (Section 71): The Department of Human Services is required to modify the nursing facility cost reports to capture data by the distinct categories of nonlicensed direct care workers for the purposes of documenting the turnover rates for direct care workers. A State Plan Amendment has been submitted to implement the cost report changes, and a revised cost report is now available to providers. An annual analysis of direct care worker turnover is required, and the first report is scheduled to be completed by December 29.

Health and LTC Access Advisory Council (Section 57). The Dept of Public Health was tasked with convening this advisory council to develop a strategic plan for health care delivery infrastructure and health care workforce resources in Iowa; provide for continuous collection of data to provide a basis for health care strategic planning and health care policy making and make recommendations on the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends and informing policymaking.

This advisory council had it's first meeting on November 24 (info available at http://www.idph.state.ia.us/hcr_committees/care_access.asp). The council is to develop a strategic plan and submit to Governor and legislature by January 1, 2010.

Direct Care Worker Advisory Council (Section 69): The Director of the Dept of Public Health was to appoint this advisory council which is tasked to advise the Director regarding regulation and certification of direct care workers and develop recommendations regarding certification, education and training, standardization requirements for supervision and functions for each direct care workers. The Advisory Council is required to submit recommendations to the Director of IDPH by November 30, 2008. Implementation of certification of direct care workers is to begin July 1, 2009.

Voluntary Employer Sponsored Health Care Coverage Demonstration Project (Section 72): The Dept of Human Services (DHS), in collaboration with the Iowa Insurance Division (IID) is required to design a demonstration project to provide health care coverage premium assistance program for non-licensed direct care workers. In addition, DHS and IID is to convene and advisory council to assist in designing the project, that allows for up to 250 direct care workers and their dependents to access health care coverage sponsored by the

direct care workers employer. The final design for the demonstration project is to be submitted by December 15, 2008.

8. Unmet needs report---is data received consistently from throughout the state? Is everyone reporting? Is a more specific breakdown on unmet needs available?

The unmet needs report is completed by the Area Agencies on Aging and compiled by the Department of Elder Affairs.

9. What is actual cost of case management?

The chart below includes expenditures for State Plan Case management, which serves the MR/DD/CMI population.

DHS - Medical Assistance
SFY 2008 Targeted Case Management Expenditures

1. Targeted Case Management Expenditures (Category of Service 98)

Month	Total $'s	Non-Fed'l $'s	County $'s	State $'s	Unduplicated Recipients	Total Cost per Recipient
Jul-07	$ 2,588,100	$ 983,996	$ 328,157	$ 655,839	8,719	$ 296.83
Aug-07	$ 2,036,106	$ 774,127	$ 255,485	$ 518,642	7,081	$ 287.54
Sep-07	$ 2,882,224	$ 1,095,822	$ 357,953	$ 737,868	8,577	$ 336.04
Oct-07	$ 2,679,513	$ 1,025,450	$ 335,469	$ 689,981	8,669	$ 309.09
Nov-07	$ 2,714,739	$ 1,038,931	$ 334,201	$ 704,729	9,493	$ 285.97
Dec-07	$ 3,214,984	$ 1,230,375	$ 400,405	$ 829,970	9,484	$ 338.99
Jan-07	$ 3,194,729	$ 1,222,623	$ 383,221	$ 839,402	9,615	$ 332.27
Feb-08	$ 2,001,850	$ 766,108	$ 312,588	$ 453,520	9,214	$ 217.26
Mar-08	$ 2,870,979	$ 1,098,724	$ 360,857	$ 737,867	10,349	$ 277.42
Apr-08	$ 2,522,832	$ 965,488	$ 322,938	$ 642,550	9,457	$ 266.77
May-08	$ 2,992,490	$ 1,145,226	$ 375,862	$ 769,364	10,054	$ 297.64
Jun-08	$ 3,637,138	$ 1,391,933	$ 434,046	$ 957,887	11,009	$ 330.38
Total	**$33,335,686**	**$12,738,801**	**$4,201,181**	**$ 8,537,619**	9,310	3,580.60

The HOME AND COMMUNITY BASED SERVICES Elderly Waiver case management is based on legislation, which has capped the expenditures. The average cost is $70.00 per month.

10. What is the status of HF617?

DHS convened an Assisted Living Taskforce comprised of individuals from the Iowa Finance Authority, Department of Elder Affairs, Department of Inspections and Appeals, Iowa Healthcare Association, Area Agencies on Aging and assisted living provider representatives, to make recommendation to the Centers for Medicare and Medicaid Services (CMS) to add an assisted living service to the Home and Community Based Elderly Waiver program under Medicaid. This was directed in 2005 in House File 617.

Per HF 617, if DHS received CMS approval on the waiver, we were not to implement the service prior to specific action by the general assembly.

The taskforce met regularly and did extensive research to develop a recommendation to add the assisted living service to the waiver. Recommendations were as follows:

- The assisted living service shall only be available to tenants of certified assisted living programs regulated pursuant to chapter 231C.
- A tiered system of reimbursement based on the level of assistance for the type, number and severity of activities of daily living or cognitive or behavioral impairments.
- A payment rate for each tier of services needed or both based on a percentage of average urban and rural modified price-based case-mix.
- Room and board costs for the tenant shall be determined between the tenant and the assisted living program.
- The current monthly maximum for elderly waiver services was $1052. It was requested that a higher monthly maximum be allowed for a consumer receiving the assisted living service under the waiver. This would allow a "carve-out" for this population in the elderly waiver to be paid at a tiered level for the assisted living service.

Based on this recommendation, the Department contacted CMS to inquire if we would be allowed to set a higher maximum monthly benefit as "carve-out" for this assisted living service. The response from CMS to DHS was as follows:
"The State can place limits on any service, but they cannot establish different payment levels for certain individuals on the waiver".

Based on the CMS response, the recommendation was not allowable. This information was shared with the taskforce. As a result, the taskforce determined there were no further recommendations they wished to pursue.

After thorough review of the taskforce recommendations, response from CMS and the fact that additional funding would be required to implement the tiered reimbursement system, a determination was made not to submit a formal waiver amendment, as we knew it would not be approved by CMS. This was addressed with DHS administration and legislative leaders and all understood the project would require further legislative action that would meet the CMS requirements. The decision was made, with the legislature and workgroup, to add Consumer Directed Attendant Care service to include Assisted Living Facilities as a provider type.

11. Assisted Living---what are other options for provision of services, regulation, reimbursement, etc.? What are other states doing?

There are other Medicaid services that may be provided in the Assisted Living provided by enrolled Medicaid providers. Some examples include home delivered meals, home health, homemaker, personal emergency response, etc. Currently, the Home and Community Based Services Elderly waiver has 17 different services that an eligible Medicaid member may receive based on their specific needs.

Some states are paying for services through 100% state funding. A few states have an approved Assisted Living Home and Community Based waiver. However, two states have submitted an assisted living waiver application within the past 12 months and CMS is concerned about providing a "bundled" service within the HOME AND COMMUNITY BASED SERVICES waiver option. To date, CMS has not approved their application request. The concern is that Medicaid is paying for a bundled "mini" nursing home service instead of individualized services as required by CMS policy for Home and Community Based Waiver programs.

Reimbursement is based on the cost effectiveness formula set by the HOME AND COMMUNITY BASED SERVICES Elderly waiver. All HOME AND COMMUNITY BASED SERVICES waiver services must be provided within the monthly cap. If this were to increase it would need to be applied to all HOME AND COMMUNITY BASED SERVICES elderly waiver recipients. DHS would need to receive legislation, an appropriation from the legislature and apply and receive approval for a waiver amendment through CMS. This would also require rule/manual changes and system changes.

12. Provider self-assessment? CDAC form? Comments?

Provider self-assessment for Home and Community Based Services was developed, as CMS has required each state to have a quality assurance process. The DHS developed the self-assessment form as a resource to the provider to review their internal policies and procedures. This allows the provider to evaluate their services and puts the ownership of quality within their own system. The DHS then reviews the self assessment for core standards and surveys providers based on random sampling (minimally every 5 years or complaints/incidences.

CDAC form-see question #1

13. What services are provided to consumers for other levels of care?

See HOME AND COMMUNITY BASED SERVICES Wavier comparison chart referenced in Question #3. Also, there is an institutional service available for individuals such as nursing facility, intermediate care facility for individuals with mental retardation and hospitals.

14. What process changes can make things run more smoothly?

Ongoing communication and training.

15. If Assisted Living isn't available, what is the difference in the cost to the state for nursing facility level of care?

If Assisted Living is not available, there are other services that could be accessed prior to nursing home entry through the Home and Community Based Services waivers. See attachment #3. The majority of individuals elect to remain in their homes as long as possible.

The average rate per day for a freestanding nursing home facility is $120.97. This only includes the cost for a nursing home but does not include any other medical costs that the individual may access. For Assisted Living HOME AND COMMUNITY BASED SERVICES Consumer Directed Attendant Care, the current reimbursement maximum is $1117 per month or $36.03 per day. Services are paid based on what the Medicaid member needs, not the maximum reimbursement as the HOME AND COMMUNITY BASED SERVICES CDAC service only pays for specific personal care activities.

16. Are we using Medicare services to the fullest extent? Compare the services and payment options under Medicare and Medicaid.

In the Medicaid payment system, specific services are identified as Medicare payable. For identified Medicare eligibles, the Medicaid claim would be denied. Also, Medicare and Medicaid share information to split the costs of services for individuals who are "dual eligible" (Medicare and Medicaid). After Medicare pays their portion, Medicaid pays the co-insurance and deductibles.

Medicare is always bill first if the Medicaid member is eligible. The payment for Medicare home services (i.e. home health aide and nursing) is based on an Prospective Payment System (based on a 60 day episode) or for facilities is limited to a number of allowed days (per episode). For Medicaid, long-term care services are paid by the visit, hour, or per day (with no limit). Therefore, is difficult to do a comparison.

17. How can availability of the option of assisted living be increased for consumers at all income levels?

Options for consideration:

- Assisted Living payment on a sliding fee scale based on Federal Poverty Level. Current Medicaid regulations do not allow the payment of room and board for Medicaid community services including Assisted Living.
- Explore possible rent subsidy based on income. Currently there is a rent subsidy allocation (100% state funding) for individual accessing Home and Community Based Services through the Iowa Finance Authority