

Medicaid Solutions Home and Community Based Services Subcommittee Members

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Betty Oldenkamp, Lutheran Social Services

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Daryl Reinicke, West Hills Village Health Care Facility

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Ann Schwartz, Department of Social Services

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Note to Readers

Governor Dennis Daugaard established the Medicaid Solutions Workgroup during the 2011 Legislative Session with the goal to solicit key stakeholders to provide input and develop strategies to contain and control Medicaid costs. The Workgroup and its three subcommittees (Pharmacy, Home and Community-Based Services, and Patient-Centered Care) met several times over a nine-month period; evaluated data; heard presentations on numerous best practices in South Dakota and nationally; and developed recommendations to help contain costs.

The Home and Community-Based Services Subcommittee's (HCBS) objective was to develop recommendations on three different service models to meet the needs of individuals who require supports and services in the least restrictive and most appropriate home environment; analyze opportunities available through the federal government; and explore reimbursement models. The subcommittee's direction was to assess the appropriate utilization of less costly home and community-based services.

Who are the South Dakota Citizens relying on Medicaid for their health care and other services?

- Over 50% of our parents and grandparents in nursing homes are dependent upon Medicaid to pay for their care. 25% need Medicaid in order to live in an assisted living facility. And, many of our parents and grandparents rely on Medicaid to pay for much needed services so they can remain living in their own homes and communities in their later years of life.
- Approximately 10,000 South Dakotans with mental health and/or substance abuse challenges receive services in their community through their local mental health centers or substance abuse treatment centers paid for by Medicaid.
- 130 South Dakotans whose disability results in quadriplegia are able to live in their own homes and apartments through the Assistive Daily Living Services Medicaid waiver program that provides personal attendant services on a daily basis.
- Approximately 300 South Dakotans who have significant disabilities and are working at jobs in the community are eligible for Medicaid health insurance

coverage through the Medical Assistance for Workers with Disabilities Medicaid program.

- Over 3,800 South Dakota citizens with developmental disabilities are living in our communities through the support of Community Support Providers, relying on Medicaid to pay for their services.
- Services provided at Children's Care Hospital and School are paid for by Medicaid.
- Citizens with developmental disabilities supported at the South Dakota Developmental Center are covered by Medicaid.

These South Dakotans are our children, parents, grandparents, neighbors and friends.

Medicaid Solutions Workgroup
Home and Community Based Services Subcommittee
Goals, Process & Timeline

Three of the eleven formal recommendations established by the Medicaid Solutions Workgroup were evaluated by the HCBS subcommittee: Money Follows the Person, Domiciliary Care and Community First Choice Option 1915(k). The goal of the subcommittee was to formulate a recommendation for each of the three programs. The subcommittee also assessed whether or not South Dakota's infrastructure can currently accommodate each program and if implementation of each program would place a greater financial burden on the state.

The subcommittee met in May, June, August and September 2012. The subcommittee had a diverse membership of health care providers, community support providers, a state legislator, advocates, Department of Human Services (DHS) and Department of Social Services (DSS) representation.

Money Follows the Person (MFP)

MFP is a federal initiative aimed at balancing Long Term Care programs. SD was one of 7 states in the nation that had not applied for MFP planning and demonstration grants. MFP helps individuals who are institutionalized in nursing facilities and intermediate care facilities to return to their home communities. In order to be eligible for MFP, the person must have been residing in an Intermediate Care Facility for Mentally Retarded (ICF/MR) or nursing facility for a period of 90 days. MFP will provide an enhanced Federal Medical Assistance Percentage (FMAP) rate for the first 365 days after a person moves from an institutional setting into the community.

MFP is viewed as a natural progression following the development and implementation of the Aging and Disability Resource Connection (ADRC). ADRC provides assistance to individuals over 60 years of age and to individuals over 18 years of age with physical disabilities, who are seeking home and community service options, regardless of income.

Proposed Benchmarks:

- Meet the projected number of eligible individuals transitioned into each target group from an inpatient facility to a qualified residence each calendar year of the demonstration.
 - Calendar year (CY) 2013 Total 25
 - 3 older adults; 12 individuals with intellectual disabilities; 10 individuals with physical disabilities;
 - CY 2014 Total 31
 - 5 older adults; 14 individuals with intellectual disabilities; 12 individuals with physical disabilities
 - CY 2015 Total 37
 - 7 older adults; 16 individuals with intellectual disabilities; 14 individuals with physical disabilities
 - CY 2016 Total 43
 - 9 older adults; 18 adults with intellectual disabilities; 16 individuals with physical disabilities
- Increase State Medicaid expenditures for HCBS during each calendar year of the demonstration program.
- Annual increase in the percentage of MFP participants that remain in the community at least one year following transition.
- At least 80% of MFP participants who receive help by another person feel their helper treats them the way they want to be treated.
- Beginning with 50% in CY2013, an annual increase by 10 percentage points in the percent of HCBS and Long Term Care (LTC) work force who receive training on long term supports and services (LTSS) topics.

Recommendation 1

The subcommittee agreed unanimously to recommend proceeding with the MFP planning grant (\$200,000 received) and the MFP demonstration grant. DSS will provide administrative oversight to the MFP initiative and provide MFP grant updates to subcommittee members. It is anticipated that the implementation of this program will not place greater financial burden on the

state and will, in fact, provide financial assistance to ensure success for people who are institutionalized to live in a home and community-based environment. It is anticipated that the transition from institutional services to HCBS waivers will prove to be a cost savings to South Dakota's Medicaid system.

DSS received notification from CMS on October 5th, that South Dakota's MFP demonstration grant has been approved in the amount of \$1,323,044 for calendar year 2013. DSS will prepare and submit a budget for each subsequent calendar year through 2016. This grant will be utilized to transition individuals from institutional settings to home and community based environments.

Domiciliary Care/Adult Foster Care

The domiciliary care/adult foster care models have been very successful in supporting the elderly, mental health and intellectual disabilities populations. These models have proven to be successful in rural areas. Some states have chosen to hire a private organization to recruit Adult Foster Homes/Domiciliary Homes. The organization through its home network provides a lower-cost community alternative to nursing home and institutional care. Representatives of DSS, DHS and Department of Health (DOH) gave presentations to the subcommittee confirming SD does not currently offer a robust Adult Foster Care program (AFC).

SD's AFC program provides a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, cognitive or visual disabilities. The typical participant is not able to live independently and is not a danger to self or others, but may need prompts or minimal cues to allow activities of daily living to not be compromised. The SD DOH provides the licensure of the homes. The DSS has established caregiver reimbursement rates that receive an annual cost of living adjustment and the funding source is general funds.

The subcommittee discussed information provided by DHS DDD about a possible pilot project for shared living, a model very similar to adult foster care. There are approximately 1,000 individuals living and receiving supports in residential settings that are supported by staff less than 24 hours a day. During recent public forums, participants have indicated a desire for smaller

sized homes and these individuals are a possible target population for a pilot. The targeted population would be current HCBS waiver participants and the pilot could be administered under the current HCBS waiver. The individuals participating would be receiving other HCBS such as case management, prevocational training, day habilitation, and/or supported employment.

The pilot would limit the number of individuals with disabilities in a home to two. The pilot would also define eligibility and licensure to be compliant with DOH Administrative Rules of South Dakota (ARSD). CMS assurances would be addressed through waiver assurances already in place through the DDD ARSD. Funding could be obtained through waiver FMAP, Medicaid State Plan, and Social Security Administration (SSA) benefits.

There is a need for reassurance amongst subcommittee members about medication management, staffing, and the ability for the participant to keep their own home. These concerns would need to be addressed prior to implementation of a pilot program. Tax credits are important and more exploration into the availability and potential benefit that tax credits could have will be important to confirm. Private funding should also be a consideration. Outreach and oversight would need to be considered as well as residence accessibility.

Recommendation 2

The subcommittee responded favorably to the idea the development of a pilot project by the DHS DDD. This pilot project would assess the feasibility of developing adult foster care services or shared living as residential options. The pilot would have a narrow focus initially (individuals with Intellectual Disabilities/Developmental Disabilities) but could eventually branch out to other populations (elderly, individuals with physical disabilities or who have traumatic brain injuries, etc.). It is anticipated that shared living options will be more cost effective than large congregate homes funded by Medicaid dollars.

Community First Choice Option 1915(k) (CFC)

The CFC final rule adds section 1915(k) to the SSA establishing a new state plan option to provide home and community-based attendant services and supports at a six percentage point increase in FMAP. The required services include assistance in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, and/or cueing. States are required to use a person-centered service plan that is based on an assessment of functional need and allows for the provision of services to be self-directed under either an agency-provider model, a self-directed model with service budget, or another service delivery model defined by the state and approved by the Secretary of Health and Human Services (HHS). States may offer more than one service delivery model. DSS and DHS representatives gave presentations to the subcommittee on current personal care options available in SD.

Personal care services are currently provided through the Medicaid State Plan to about 700 statewide participants, many of whom are elderly and/or individuals with physical disabilities. Services are provided through the Medicaid State Plan under DSS authority, ARSD §67:16. Personal Care is not an extensive service but has many advantages including statewide accessibility, it is already an available state plan service, there is limited reporting required, and utilization is controlled by limitation of hours per consumer per month.

Both DDD waivers include personal care as a service. In the CHOICES waiver it is called residential services; in the Family Support 360 waiver it is called Personal Care 1 and Personal Care 2, which is utilized after the state plan personal care is exhausted. Personal Attendant Care in the Assistive Daily Living Services (ADLS) waiver is very similar to the state plan personal care, but can provide more coverage - up to 42 hours per week. To be eligible for this service, the recipient must have functional limitations in all four limbs.

CFC is a Medicaid State Plan option that allows states to provide home and community-based attendant services and supports in community settings. Requirements include institutional level of care, person centered service planning based on a functional assessment, statewide availability, allow for self-direction, a continuous quality improvement plan, and the creation of

a Development and Implementation Council.

Recommendation 3

The subcommittee unanimously agreed that the CFC may not be the best option due to concerns about its required state wideeness which would not contain Medicaid costs in South Dakota. It is also worth noting that a majority of states have not elected this option due to similar concerns. The DSS provides personal care services through South Dakota’s Medicaid state plan. The DHS provides personal care services through its HCBS waivers. The subcommittee recommends that the consideration of implementing a Community First Choice Option 1915(k) be set aside while continuing to monitor for any future potential developments or benefits. The six percent increase in the FMAP would not be a cost savings given the current limited use of personal care services in South Dakota and it is anticipated that future requests for services will not increase significantly.

The Department of Social Services and the Department of Human Services wish to acknowledge the work completed by the subcommittee members. Thank you for your time and efforts in reviewing information, attending meetings and participating in discussions to identify recommendations for Medicaid solutions.

The subcommittee wishes to thank Governor Daugaard for the opportunity to address Medicaid solutions for South Dakota and provide home and community based environments for SD’s citizens.

The recommendations outlined in this report should be viewed as a multi-year plan to explore Medicaid solutions.