



**North Carolina Department of Health and Human Services**  
**Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

3001 Mail Service Center • Raleigh, North Carolina 27699-3001

Tel 919-733-7011 • Fax 919-733-1221 • Courier 56-20-24

Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

Richard J. Visingardi, Ph.D., Director

July 3, 2003

**MEMORANDUM**

To: Area Program Directors

From: Richard J. Visingardi, Ph.D.

Re: CAP-MR/DD Waiver (1915[c] waiver) Transition

**Introduction**

Effective July 1, 2003, the CAP-MR/DD waiver program will move to a statewide aggregate funding strategy managed by the local public systems. This will involve each Area Program being provided a global "virtual budget" (allocation) along with an expectation that a minimum number of individuals be enrolled as c waiver recipients. As this is a major transition year, the focus will be on creating and moving toward a system that reflects a more reasonable and efficient use of the c waiver. We will be developing the path to the new c waiver, which will be completed and fully implemented by no later than July 1, 2004. It would be our desire that the long-term strategic intent of the c waiver would include advancing the overall concept of global budgeting.

The purpose of this communication is to provide initial direction regarding the changes. This includes a brief description of the waiver and its history in order to set the framework for the changes that the system must embrace. The area programs, as emerging LMEs, are charged with managing this valuable resource. The State looks to the LME, as the community leader and the organization responsible for operationalizing public policy, to convene energies around the consumers who are currently receiving or waiting for services including those individuals who are residing in mental retardation centers who are waiting to return to their home communities.

This transition memo provides explanation and guidance to assist in the revitalization of the waiver as an important resource of supports and services for persons with mental retardation and developmental disabilities. Dialogue between area program/LMEs, CAP-MR/DD service providers, consumers and families is the next step towards putting the information contained in the memo into practice.



It is important to note that this correspondence is only intended to initiate the public partnership and dialog necessary to both work through this transitional year and move toward the evolution of a much better model. Therefore, although some of the information contained in this memorandum provides responses to issues, none of the information provides the kind of full understanding that would only occur through the richness of our on-going conversations and problem solving efforts. In addition, some of the contents of this communication will raise new questions for us to jointly address. As in any change process, we simply need to be open and flexible.

## **What is the CAP-MR/DD Waiver?**

### **▪ Subset of Medicaid**

Waivers are a subset of the federal Medicaid medical insurance program. Medicaid was designed to provide defined services to the most vulnerable of our population who could also not afford to pay for medical care on their own. The services Medicaid will pay for must be determined to be medically necessary for a person and must address the identified medical needs. Testing all services against medical necessity historically meant that full or partial payment would be made for acute, short-term medical treatment and inpatient hospital or institutional care. The Federal Medicaid statute requires a state to specify the amount, duration and scope of each service that will be paid for by Medicaid funding, and who will be considered eligible to receive the services. The first criterion of eligibility for Medicaid is financial.

In 1971, legislation was added allowing states the option of paying for long term care in intermediate care facilities (ICFs) and/or for persons with mental retardation in ICFs-MR. Adding this coverage made it possible for states to use federal money to help pay for the support of persons needing this level of care. As knowledge about serving people in their own communities began to grow, Congress passed legislation in 1981 establishing the home and community based services (HCBS) waiver authority. HCBS allows a state to set aside a portion of the money that it would normally spend providing institutional care to pay for the support of individuals in the community. Each waiver must identify a specific level of care to be “waived” and identify a specific population to be served. If a state is not covering a particular type of institutional service in its Medicaid plan, it is not able to offer the waiver option for that type of service in the community. A HCBS waiver is covered under section 1915(c) of the Social Security Act-- thus, it is referenced as a 1915 (c) waiver.

### **▪ Contract Between the Federal and State Governments**

The 1915 (c) waiver is a contract between the state and the federal government, in which the state agrees to serve a specified number of persons who would qualify for the institutional level of care based on their medical needs, in the community instead of in an institution. A part of the contract also specifies that the number of persons identified will be served in the community at equal to or less than what the cost would be to serve the same persons in the institutional setting. Each waiver must be managed to assure it does not exceed this requirement for “cost neutrality.”

The state operating a waiver specifies that persons served in the community will receive services that cost less than or equal to what services in the institutions cost. Institutions are responsible for providing all of the habilitation services and most of the medical needs of their residents. (Some intense hospital-based services are not provided in institutions.) A waiver contains a list of services



designed to match the types of services in the institutions but offered in the recipients' home or other community residential setting. Because the recipient must meet financial eligibility for Medicaid, the recipient also has access to the state's regular Medicaid plan for payment of medical services. To meet the test of cost neutrality, the state must calculate the combination of services paid for by the waiver and services paid for by the state Medicaid plan at equal to or less than what it would cost to serve the same number of persons in an institution.

North Carolina has several waivers. Each one defines a different population and the level of care that is "waived" for that population. CAP stands for Community Alternatives Program because the waiver is an alternative to the institutional level of care that allows the recipient to live in the community. There are waivers for medically fragile children, CAP-C; for disabled adults, CAP-DA; and the MR-DD waiver is for persons with Mental Retardation and/or developmental disabilities.

### ▪ **Criteria for Eligibility**

The CAP-MR/DD waiver has two criteria for eligibility. The first is eligibility for Medicaid. In North Carolina, a person must be at or below the poverty rate in order to qualify for Medicaid. One element of increased flexibility in North Carolina was the decision to let a child be considered a "family of one." This means that a child's income is counted separate from that of the parents. This option means that virtually every child in the state, who meets the other criteria for eligibility, is considered eligible for the waiver. It also means that families who are low to moderate income, but above the poverty level, can get assistance for the support of their children without incurring all of the medical expense that would otherwise be necessary.

The second criterion for eligibility is the "level of care." A physician must certify that a person, child or adult, has the diagnosis, conditions, needs that are defined in the state as mental retardation and/or developmental disability. The definition of developmental disability is stated in General Statute (G.S. 122C) as follows:

Developmental disability means severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the person attains age 22, unless the disability is caused by traumatic head injury and is manifested after age 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitation in three or more of the areas of major life activity: self care, receptive and expressive language, capacity for independent living, learning, mobility, self direction and economic self-sufficiency.

AND

- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services which are of a lifelong or extended duration and are individually planned and coordinated.
- When applied to children from birth through four years of age may be evidenced as a developmental delay.



## **History of CAP-MR/DD**

The CAP-MR/DD waiver opened in 1983 in four area programs with expectations of serving 2,800 consumers at a projected average of \$18,285. The popularity of the waiver and its services created tremendous demand and growth both in the number of persons served and the amount of services each person received. This growth began to exceed the budget for the waiver such that in 2000 the waiver was “frozen” allowing no new persons to come into service. This year the waiver will serve 5,690 persons at a statewide average cost of about \$43,000 per person (waiver services only, does not include the cost of Medicaid card services such as Physical Therapy, Speech Therapy, etc.) for a total budget expenditure of \$260 million dollars. The management of the number of persons to be served, and the cost, and the distribution of cost and services across the state, has historically been managed by allocating “slots” for waiver recipients to area programs. The state stipulates how many persons will be served per year in the waiver document submitted to the federal government. The vacancies for the number of persons to be served have historically been distributed to area programs as “slots.”

## **Waiver Funding**

### **▪ Declarations of Cost Neutrality**

States operating waivers must stipulate within their waiver document to the federal government, what level of care is being waived, and what the annual cost is of that level of care. Historically, North Carolina used the average cost of community ICFs-MR which, in 1999 was around \$68,000 per person. While most states calculate their estimates of cost neutrality “in aggregate,” North Carolina has always attached the cost neutrality requirement to each individual consumer served on the waiver. This means that, in other states, how much is spent on all of the persons in the waiver statewide, plus their Medicaid costs, is compared to how much the state would have spent had the same number of persons been served in the waived level of care institutions. Aggregate calculations for cost neutrality results in some consumers being able to receive services in excess of the cost of institutional care because their cost is balanced by other consumers that need far fewer services. North Carolina has required that each individual served through the waiver not exceed the cost of services in the community ICF. This means that no one person could exceed the \$68,000 per person/per year test of cost neutrality.

The state, however, does not fund the waiver at the maximum amount of service available per person (or per slot) because not every person on the waiver needs the full \$68,000 of services. All waivers have a mixture of persons with high needs and persons with lower needs, resulting in the total number of waiver slots being funded at a statewide average. For example, in 1999 when the maximum amount of services a person could receive was \$68,000, the slots were funded at the statewide average of \$37,000 per person, per year.

### **▪ Medicaid and the Waiver**

Medicaid services are an entitlement. Anyone with a Medicaid card presenting for service must be allowed to receive the service. The state must pay its portion of the cost of these services each year. The waiver is optional to the state, and the state is not required to exceed its waiver budget. For every \$1.00 of service paid for within the waiver, the state must pay approximately \$.40. The



state's annual waiver budget is based on the 40% of the total spending allowed for consumers on the waiver.

A state has the prerogative to set an upper service limit on its waiver as long as the limit is at least equal to the cost of ICF-MR care. In 2000 and in response to requests from families in conjunction with conversations with the Health Care Finance Administration (HCFA, now known as the Centers for Medicare and Medicaid Services or CMS), North Carolina increased the upper limit from \$68,000 (which was tied to the cost of private, community ICFs) to an average of the private community ICFs and the state operated mental retardation centers. The new upper limit was \$86,058 per person per year. However, until October of last year (2002), the legislature did not increase the budget for the waiver. This meant that, as the average cost per person rose, the only way to maintain the budget was to restrict any new consumers from becoming waiver recipients.

### ▪ **Waiver Budget**

Even though no new consumers were allowed to enter into waiver funded services, the costs per person continued to rise from \$37,000 to \$40,000, \$43,000 and then \$45,000. Although the waiver budget was set at \$228 million dollars, the service costs were exceeding \$248 million in 2001-2002 and on track to exceed \$264 million in 2002-2003. The trend in increased spending brought several crucial issues into focus:

- the error of perception of slot “ownership” and “entitlement”;
- the concept of a slot equal to an amount of money;
- fear of losing a slot;
- a question of service “need” versus service “want”;
- a lack of effective, responsible utilization management;
- deficiencies in person-centered planning;
- a divide between consumers receiving the full benefits of the waiver as compared to those receiving no services.

### ***The error of perception of slot ownership and/or entitlement:***

While participation in the Medicaid program, on the basis of financial eligibility, is an entitlement, participation in a waiver is an option for the state. No state is required to provide waiver services although every one of the fifty states does so. Waivers are preferred for the flexibility of the services they offer, for the best practice approach of allowing consumers to remain in the most natural community settings possible, and for the cost efficiencies when compared to institutional services. When persons have waited, sometimes years, to be able to receive waiver services, and are then awarded a “slot” it is natural to feel a sense of ownership of the slot. Much of North Carolina's previous communications about the waiver have been to present it as a “program.” If a consumer has a CAP slot, he/she has access to services not available to other persons. The waiver stipulates an upper limit of \$86,058 per person/per year. This upper limit has been misconstrued as a budget that is available to everyone on the waiver generating conversations about, “how I can spend my \$86,000 dollars on services and equipment this year.”



### ***The concept of a slot equal to a certain amount of money:***

The waiver is not a cash benefit program. It is insurance. The consumer does not have any rights to cash or to a cash sum of money. The consumer/family does have a right to the services and supports defined within the State Medicaid Plan and the waiver to meet their medical and habilitation needs. In some states, as will occur in North Carolina in the future, consumers and families are allowed some flexibility in how the services and supports are paid for and organized. Similar to a waiver within a waiver, some states calculate the amount that the state would pay for a package of services and supports and then allow consumer/families to take on more responsibility for hiring, training and managing their direct care staff by increasing the flexibility of how the identified sum of money will be spent. Unfortunately, in some areas of North Carolina this process of self-determined access to service has been interpreted to mean a checkbook with a balance of \$86,000 each year to spend. This is not only an incorrect assumption for how self-determination might work in North Carolina, it is not how consumer-directed supports work in any state. North Carolina has much preliminary work to do before being prepared to offer maximum flexibility for consumer directed supports.

### ***Fear of losing a slot:***

The state and area programs have contributed to the perceptions of ownership and entitlement. In some area programs, families were told that they weren't using enough services to continue to qualify for the waiver and they must use more in order to continue to be a waiver recipient. Families who truly only needed access to the services in the Medicaid State Plan, such as physical, occupational, or speech therapy, and a little respite, were informed of the need for receiving some habilitation services in order to continue to occupy their slot. The idea was that if a family did not use the waiver services they must not need them and therefore should be removed from the waiver to be replaced by someone that had a higher need as would be evidenced by using more waiver service. In addition to contributing to the perceptual problems, the entire waiver system helped to build the idea that those who used the most must be the most in need and, as such, remain guaranteed a slot on the waiver.

Competition for a waiver slot, based on need, also meant that families that could effectively communicate higher need would be considered first for vacant slots. Sometimes that meant families turning down other options for support and services to avoid being perceived as having some needs met and therefore not as needy for the CAP-MR/DD waiver slot.

### ***The question of “need” versus “want”:***

The law that created the waiver program in 1981 permits the federal government to approve a wide range of services and supports for waivers as long as they are necessary to avoid institutionalization and are cost effective. In essence, this means that while a consumer must be determined in need of a certain level of care, such as ICF-MR, in order to be eligible for participation in a waiver, the services that are delivered to the consumer must also meet a test of being necessary to aid the consumer in avoiding institutionalization. In some instances in North Carolina, there is evidence that families, case managers, area programs and providers have acted on the premise that once a consumer has a slot they are then entitled to any and all of the services, supports, and equipment available within the waiver, regardless of their true need.



Historically, the case manager would have been responsible for working with the consumer/family to identify which services, supports, and/or equipment would allow the consumer to remain in their own or their family's home. As the planning process shifted to more person centered practices, the concept adopted was to allow for the consumers/families to have a greater voice in identifying what they felt was needed. The role of the case manager shifted as well from advocate to a blend of advocate and system manager. The resulting confusion meant that no one has had a clear line to distinguish what is necessary from what is highly desirable. Unfortunately, the line is often defined by the skill of the developer of the plan of support and the level of sophistication of the advocacy on behalf of the consumer/family.

Distinguishing "need" versus "want" is indeed a complex issue. It is very appropriate that a person-centered plan reflect the full life desires of an individual. What is often confused is that "wants" or "needs" are equated with "supports and services". An individual both "needs" and "wants" real life outcomes-- housing, employment, relationships, as examples-- however these are not supports and services. An individual "needs" a path to get to their desired life outcomes-- these may include supports and services. Furthermore, these "supports and services" may or may not be paid for with the public specialty system resources.

The key to this issue lies in determining the strategies to reach the ends. In developing these strategies, the following are some areas that require both local based community discussion as well as Division-Area Program discussion:

- A person-centered plan is a person's life plan. The plan is not about simply "selecting and organizing" publicly sponsored supports and services but rather identifying and clarifying real life outcomes and looking for a variety of ways to support the pursuit and achievement of the outcomes. This includes acknowledgement that every "need" of an individual does not require a "publicly paid for" response.
- A "need", in Medicaid terms, speaks to a medically necessary covered benefit that will contribute to the achievement of a life outcome. For example, an individual may "need" in-community support to maintain a supported living arrangement. In this instance, the individual may very well meet the criteria for Medicaid reimbursed supports. However, there may be some other resources that could contribute to this outcome.
- There is a need to recognize the concept of "reasonableness"-- both related to what a consumer may want as well as what the system may see as necessary to provide.
- The person-centered plan reflects a negotiated process. It is not a consumer "carte blanche" plan nor is it a plan riddled by systems barriers.
- The consumer's role includes responsibilities to act as an informed and prudent purchaser in the application of any publicly sponsored supports and services. The systems role is to assure that the consumer has the information necessary to make these prudent purchasing decisions.

The above is a limited list of oversimplifications of a complex issue. This is also an issue that will never be fully resolved through any directive or communication published by the Division. As part of the general reform efforts, the Division will be working to provide more direction in this area as well as related areas. However, the local dialog needs to begin now. This will raise all stakeholders'



awareness and informed ability to participate in the problem solving process, which will, in turn, influence the direction provided by the Division.

***A lack of effective, responsible utilization management:***

All too often, the situation surrounding the lack of effective, responsible utilization management has been boiled down to the question of “how to say no” to consumers/families who request services. This is an unfortunate oversimplification of the issues. All parties to the waiver, consumer/families, area programs, providers and the state, desire fair and equitable distribution of the resources of the waiver in the form of services supports and equipment. In addition, these same stakeholders are unanimous in their desire to see the maximum number of persons possible have access to the waiver services/supports. However, the undercurrent of fear about any potential loss of services or funding polarizes conversations. Instead of being able to discuss what a family needs and what is fair payment for those needs, the presentation is framed in terms of denying services and/or paying inadequate rates for direct care staff to provide the services.

A system of utilization management is simply a set of guidelines to assist in determining what is a typical set of services/supports and equipment that a person with a given set of needs might require to avoid institutionalization. The determination of what is typical is based on researched comparisons of the types and amounts of support used to benefit others with similar needs. No stakeholder within the system wants to “just say no” to a consumer/family’s expressed need or desire for services and supports. In order to provide the maximum supports available to the maximum number of persons in need, the state must design a system to distribute the resources as equitably as possible. As we move forward to better apply person-centered planning and practices, we will better understand the process of negotiating outcomes and strategies-- concerns regarding "saying no" should virtually become a non-issue.

***Deficiencies in person-centered planning:***

Included in the discussion about utilization management must be the process of genuine person-centered planning. For a responsible case manager in a person-centered planning process, the question of fulfilling a consumer/families request is not about simply saying “yes,” or “no.” It is more about the strategies to achieve real life outcomes. If a stated need or desire can not be funded with public dollars, the case manager is expected to seek access to other resources to satisfy the need, and not always in the form of financial payment or support from other resources.

***A divide between consumer’s receiving full services and those receiving none:***

North Carolina has citizens who are potentially eligible to receive waiver services that are receiving no services at all, waiver or non-waiver. In the meantime, over the past three years, while the amount spent per person per year has grown from \$37,000 to \$45,000, the actual number of persons participating in waiver services has declined. This means that those on the waiver are receiving more services, per person. The net effect is that these increases prevent any new consumers from coming into service. As consumer/families fearing losing a waiver slot increase services beyond their needs to guarantee retaining the slot, the budget goes up. As the budget goes up, the only way to attempt to control the budget is to “freeze” slots so that no new persons can come into service. For the past three years, it has been evident that these mechanisms to control cost have not been effective. While the waiver has not yet been in jeopardy of exceeding the federal requirements for



cost neutrality, it has consistently exceeded the amount of state dollars budgeted for the state match. The state has filled the shortfall with funds from other resources. Obviously, this budgeting process is unacceptable-- the budget needs to be managed.

### **Aggregate funding**

DMH/DD/SAS and the State Plan for System Reform have identified steps to move towards balancing the issues of budget and availability of waiver services and move to a more efficient way to manage the waiver. The first of these is to change from “slot management” to aggregate funding at the area program level. Previously, area programs were issued slots and asked to report slot activity to the Division CAP office. A database maintained at the Division was used to track the use of slots, and a reporting process attempted to reconcile the names and numbers reported by the area programs with those in the central database. As explained earlier, while this proved an effective system for limiting how many persons entered the waiver for service, it did nothing to manage the overall spending within the waiver budget. While area programs were responsible to review plans and authorize services, they were not given an indication of what their budgetary limits were as a subset of the statewide waiver budget.

In March of this year, the Division moved to an aggregate funding system for managing the waiver budget with area programs. Division staff examined the billing histories of all of the consumers within the waiver by area program. The histories were then used to project, including the current trend of inflation, how much money each area program would be on track to authorize for waiver recipients for this fiscal year. This annual figure is to be considered a baseline for budgeting for aggregate funding in the next fiscal year, 2003-2004.

During the training conducted in March, the area programs were presented with a “virtual budget” to be the amount of money they were/are on track to authorize for waiver services for this fiscal year. They were asked to examine this information and to establish whatever internal reporting mechanisms they might need to track the information and to be able to state at the end of the fiscal year whether or not they had operated within their virtual budget, if they had been under budget, or had exceeded the projected amount.

The waiver funds are referred to as a “virtual budget” because no money is actually moved into the area programs’ accounts for expenditures. The money for waiver services is paid at the point of billing which is after service delivery and involves a 60% payment from federal funds, an approximately 36% payment from State funds and the remaining 4% from local matching funds. The area program is, however, expected to manage the expenditures through the control of service authorizations. Prior to the move to aggregate funding, area programs were not required to track the costs of the services they authorized for waiver recipients. As they move towards becoming Local Management Entities (LMEs) through State System Reform, they will be responsible for both authorizing services and for doing so within a fixed budget.

### **Changes in Prioritization**

The move to aggregate funding also prompts a change in how individuals seeking waiver services are considered for waiver participation. If the prioritization remains fixed on only those of highest need, then the area programs average cost per person will remain high and they will not be able to bring many new persons into service. On the other hand, if a consumer/family has very low service



needs, their case becomes a balance at the lower end of the average and actually ends up supporting the participation of the higher needs consumers while opening up the waiver to a greater number of consumers overall. Area programs are no longer required to submit slot information to the Division. They may serve as many persons as possible and reasonable within their virtual budget. They are still required to maintain a list of active waiver consumers and the list is to be available to the Division for annual reporting by the Division to CMS.

Access to waiver services was previously determined by an expression of need before the area program's single portal authority. In accordance with the single portal legislation, area programs developed systems for prioritizing the needs of consumers, as presented, to allow those with the most need to access the limited services. The move to aggregate funding requires each area program to re-examine the effectiveness of their single portal requirements and other mechanisms for accessing services. As discussed above, the ability to serve those with lower demonstrated need becomes more attractive in an aggregate funding managed system.

The move to aggregate funding also means that families who need fewer services, particularly those medical services available through the Medicaid state plan, may receive those services without feeling they must increase their service utilization in order to justify retaining a slot. This is also part of balancing costs so high need as well as low need consumers can be responded to.

### **Expansion dollars**

In October of 2002, the General Assembly increased the allocation for the waivers budget for North Carolina. The allocation was divided among all of the waivers the state offers and the portion dedicated to the CAP-MR/DD waiver increased the budget from \$228 million to about \$302 million. While this increase, in effect, saved the waiver from the projected overspending by \$36 million, it also included an expectation, on the part of the lawmakers, that the waiver would serve new persons.

Along with the training provided to area programs in March about the move to aggregate funding, the state provided "expansion dollars" to ten pilot area programs. The ten pilots for expansion funding are: Albemarle, Duplin-Sampson, Wayne, Sandhills, Wake, Orange/Person/Chatham, CenterPoint, Piedmont, Mecklenberg and Smoky Mountain area programs. In order for the concept of aggregate funding to be successful, the fiscal allocation must have sufficient numbers to allow for some consumers to be over the average as well as some under the average. If only three person's worth of funding was to be allocated, there would be very little flexibility for differences between their service needs. The Division estimated that the average amount per person times a minimum of ten persons would be a minimum starting budget to allow an area program to begin to bring new consumers into service using aggregate funding management techniques. In addition to the base of ten, staff considered the percentage of persons waiting for services who are potentially eligible for CAP at each area program and the number of persons currently living in institutions who have been identified as Olmstead eligible and would like to return to their home community. The number of persons per pilot site was multiplied by the state-wide average of \$43,000 per person (the amount that was the state-wide average at the time of the calculations) and assigned as an additional virtual allocation of expansion dollars to these area programs to use to bring new persons into service. This does not mean that every person brought into service is considered to have a limit of \$43,000 of waiver services available to him or her. On the contrary, just like the current



utilization of waiver services, it is expected that there will be some consumers receiving much less than the average, and some that require more than the average.

The Division's expectations, as articulated in the training, are as follows:

- a) bring new persons off of the wait list into the waiver. Although a "target" was set based on the average funding per person/per year, if an area program serves fewer or substantively more consumers, the Division will request further dialog to understand the elements active in the catchment area that affect the variances.
- b) "bringing into the waiver" from the wait list was defined as a consumer receiving a minimum of waiver case management plus at least one other service with the development of a person-centered plan in progress.
- c) "bringing into the community" from an institution was defined as either physically moving a consumer out of an institution by June 30, 2003 or having a written plan that projects movement from the institution within 90 days of June 30, 2003.

The Division did not tie any negative consequences to the failure to move consumers, however, if the process is not successful, there is an expectation of participation in continued dialogue to identify barriers and strategies for change. The plan for next year's budget process is to use the same formulas to project distribution of the remaining expansion monies across all area programs.

### **Olmstead Consumers and Expansion Dollars**

Area programs are allocated expansion dollars on the basis of the statewide average expenditure per person/ per year of \$43,000. This includes the funding made available for persons being brought out of institutions. The Division fully anticipates that many of these consumers will not only cost more than the average, but that some of them will require more than the maximum value of services available on the waiver (\$86,058.). The Division has offered two options for addressing this situation.

A person who is moving directly from a state operated mental retardation center (MRC) to the community may access Trust Fund monies to cover start-up and one time costs for support of the consumer. Start up costs may be paid for tangible items necessary for the consumer such as furniture, equipment, etc. Funding to pay for additional staffing may be considered as start up costs but must include a plan for reduction of the extra staffing by the end of the first year in the community. In addition, if the consumer qualifies for MRMI funding, by virtue of having a dual diagnosis, the area program may use MRMI funding, within their current allocation, to provide additional needed supports. In essence, the area program has potential access to three funding sources to support the de-institutionalization of Olmstead identified consumers.

Area Program/LMEs can request Trust Funds to assist in de-institutionalization by submitting a letter indicating the amount of funding being requested and a plan for the use of the funding. The plan must identify specific consumers that will be moved out of the institutions in benefit of the use of the Trust Funds. The letter of request and plan should be submitted to Stan Slawinski, Chief, State Operated Services Section of the Division in care of Emunda Reed.



The community ICF-MR programs also are part of the community array available to persons exiting the state operated MRCs. This includes consumers who are currently residing community ICF-MR residential settings moving less restrictive settings in the community. This process of movement of consumers through the array is also considered to be a satisfactory way to address the need to de-institutionalize individuals. It is important to remember that persons moved to the community ICF-MR setting continue to be considered eligible for movement to less restrictive settings and the area program remains engaged in the planning of their care.

The pilots for expansion dollars received a list of the persons that were understood to have been identified as “Olmstead eligible.” During the training, questions arose as to which lists the Division had used, those compiled by the area programs, the ones prepared by the MRCs, or the ones developed by the private assessments done a year ago. The Division appreciates that there are discrepancies in the lists and in recognition agrees that the area programs, as the agents responsible for coordinating the de-institutionalization efforts on behalf of consumers may identify the persons that they wish to serve and to bring into their communities. As persons are moved out of the MRCs, there will be fewer choices regarding the order in which they are served, however, the initial flexibility allows area programs and communities to develop service and support networks and infrastructure to facilitate the movement of other consumers in the future.

## **Case Management**

In March, a memo went out to all area programs announcing a change in CMS interpretation of choice in case management for the CAP-MR/DD waiver. Previously, CMS had supported the waiver case management as being delivered only by the public sector area programs and the element of choice was defined as a choice among the case managers employed by the area program. The new interpretation stipulated that consumer/families could request to have their case management be provided by a private provider. In order to be in compliance with the new interpretation, the area program receiving a request from a family to have private provider case management would have to pursue a contract with the private provider for the provision of the service.

There is not currently a system to allow for direct enrollment or direct billing of CAP-MR/DD case management. In addition, the blended rate for CAP-MR/DD case management includes the responsibilities and functions of the area program as a Lead Agency. An area program may contract for that portion of the case management rate that is tied to direct activity with the consumer. As the system adjusts to the new interpretation and related system reform efforts are further operationalized, the case management rate will be reviewed. Private providers interested in providing case management will be expected to be a part of the area programs' provider network. Issues regarding the revised definition of case management for persons with developmental disabilities as “Supports Coordination” are addressed in the revised State Reform Plan, 2003-2004.

## **Changes in the State Management of the CAP-MR/DD Waiver**

In the spring of this year, the Division reorganized along functional lines to provide a better cross-disability response to issues confronting our system. As a part of the reorganization, branches that were devoted to the support of individual funding streams, and/or populations, were dissolved. The



functions those Branches performed were redistributed across the newly formed functional teams. An example of this re-structuring was the dissolution of the CAP-MR/DD branch within the Operations Branch of the former Developmental Disabilities Section. The transition continues in the re-distribution of some functions, however, the following changes are to be considered effective upon receipt of this memo:

Appeals	All waiver appeals will follow the Medicaid appeals process. Appeals will go directly to the Consumer Advocacy and Consumer Affairs Section for review and assignment to a Division Hearing Officer.
Local Approval	Training of local approval staff will be done by area programs rather than by the Division. It is important that area programs maintain both trained local approval staff and trained back-up to that staff, however, Division staff will not longer conduct the training. The local approval plans become a part of the LMEs' local business plans. In accordance with the current waiver, the plans are still subject to review and approval by the Division of Medical Assistance (DMA).
Augmentative Communication Devices	Training was offered to assist area programs in certifying an individual to review requests for augmentative communication devices. Upon approval by DMA, effective April 1, 2003, the authorization for purchase of augmentative communication devices paid for by waiver funds rests with the area programs and does not require a review by Division staff.
Contracting for Case Management	While area programs have contracted for other services, including Medicaid case management, the Division recognizes that there may be some questions regarding contracting for waiver case management. Patti French has prepared a frequently asked questions (FAQ) document that will be posted to the Division web-site to address some of these issues.

### **Who to Contact for Specific Waiver Questions In the Re-organized Division**

While there is no longer a waiver branch, the functions that are vital to the waiver remain within the new functional organization of the Division. It is important to remember that the new Teams do not operate in isolation, but instead work across multiple teams to achieve the tactical outcomes identified in the State Plan. For example, while the Regulatory Team is clearly responsible for the development of new waivers, the members of that team would not do so alone. They would be responsible for assembling a Waiver Development Group that might consist of members of the Best Practice Team, the Budget Team, and the LME Team in addition to other external stakeholders. The following is a list of the functions that typically generate interaction with Division staff, and a listing of who to contact with questions. Ms. Lisa Haire will remain as the lead person for this cross-organization effort in the interim. Other critical Division members of this team are as follows:



<p>Regulatory Team Team Leader: Darlene Steele (919) 420-7934</p>	<ul style="list-style-type: none"> <li>• Claims Processing requiring manual over-rides in the system: The current waiver has limits on the number of hours of respite that a consumer can receive. Exceptions must be approved by Division staff and those approved require a manual over-ride of within the billing system.</li> <li>• Liaison with Children’s Special Health Services</li> <li>• Interpretations of CAP-MR/DD regulations requested by area programs, family members and provider agencies.</li> <li>• Development of new waiver(s) and/or technical amendments to the existing waiver.</li> </ul>
<p>Advocacy and Consumer Services Section Section Chief: Chris Phillips. (919) 715-3197</p>	<ul style="list-style-type: none"> <li>• Exceptions: The availability of exceptions to the services limits stated in the waiver requires that the Division continue to review the requests for exceptions until a new waiver is written.</li> <li>• Appeals</li> <li>• Concerns and/or complaints by consumers and/or families including those with Wait List issues.</li> </ul>
<p>Accountability Team Team Leader: Jim Jarrard (919) 881-2446</p>	<ul style="list-style-type: none"> <li>• Local Approval monitoring and follow-up</li> <li>• Questions from providers about enrollment, procedures, etc.</li> <li>• Investigations of providers based on consumer complaints or as follow up to DMA inquiries.</li> </ul>
<p>Best Practice Team Team Leader: Bonnie Morell (919) 715-2774</p>	<ul style="list-style-type: none"> <li>• Curriculum development for aspects of waiver training such as person-centered planning.</li> <li>• Service arrays and/or service design for special populations such as the deaf and hard of hearing or persons with Traumatic Brain Injury.</li> <li>• Research into best practice models of service delivery and self-determination appropriate for waiver funding.</li> </ul>
<p>Budget Team Team Leader: Leza Wainwright (919) 733-7013</p>	<ul style="list-style-type: none"> <li>• Virtual Budget and/or allocation questions</li> <li>• Rate issues</li> <li>• Transfer of funds between area programs when a consumer relocates</li> <li>• Requests for emergency funding requests</li> </ul>
<p>LME Business Team Team Leader: Dick Oliver (919) 715-1294</p>	<ul style="list-style-type: none"> <li>• Special situations that appear intractable between area programs, providers and consumers. The LME Team liaison will take a lead roll in facilitating discussions to resolve these issues.</li> <li>• Technical assistance to manage aggregate funding</li> </ul>
<p>Quality Management Team Interim Team Leader: Spencer Clark (919) 733-0696</p>	<ul style="list-style-type: none"> <li>• Receives submission of incident reports and coordinates follow-up through referral to other appropriate teams.</li> <li>• Review quality assurance plans in accordance with CMS Quality Protocol for waivers.</li> </ul>



Training and Communications Team Team Leader: Joan Kaye (919) 733-7011	<ul style="list-style-type: none"> <li>• Publication of manual and manual revisions</li> <li>• Posting of updated information to the Division web-site.</li> <li>• Arranging for communications and training and notifying the field of the availability of each.</li> </ul>
State Operated Services Chief: Stan Slawinski (919) 733-3654	<ul style="list-style-type: none"> <li>• Requests for Trust Funds use as start up costs in support of Olmstead consumers moving from institutions.</li> </ul>

### Next Steps in Waiver Development/Changes

The Division, along with DMA, submitted a technical amendment for the current CAP-MR/DD waiver to CMS on May 11<sup>th</sup> with a cover memo requesting an expedited review. The changes requested are relatively minor, mostly involving changes in language to reflect the reorganization and the state plan reform. The technical amendment does change the definition of respite to remove the word “irregular” and allow the service to be scheduled on a regular basis. Notification of approval of the technical amendment will be distributed as soon as a response from CMS is received.

A new waiver is being developed to replace the current CAP-MR/DD waiver. Service definitions for this waiver are blended to mirror a more true reflection of the typical make-up of a consumer’s day. While there are fewer services proposed, the definitions are more flexible in their ability to support consumers. The new waiver also calls for respite and personal care to be available to consumers through a family/friend model that would use vouchers to allow consumer/families to purchase these services on their own. There are still several functional elements to be decided such as rates for services, the technology to allow for vouchers, etc. The waiver will include a request to allow for six months of transition to move consumers from the current waiver to the new waiver. When the elements are in place, the waiver will be submitted to DMA for approval and submission to CMS. The goal is to complete all of these tasks as soon as possible, but to have the waiver in place no later than January of 2004, such that all consumers are transitioned to the new, more flexible services, no later than July of 2004.

In addition to the new waiver, the Division has researched a new definition to propose to replace the current Community Based Service (CBS). CBS may be incorporated into a new service array for persons with mental illness and substance abuse and the change may mean that the service is no longer available to persons with diagnosis of mental retardation and/or developmental disabilities that do not also have mental health or substance abuse diagnoses. The Division is recommending a substitute service, Developmental Therapies, that may be incorporated into the Medicaid State Plan.

The Division has also drafted a proposed set utilization management (UM) criteria to apply to all individuals with MR/DD receiving Medicaid services if they are participating in the waiver or not. The criteria define six levels of care and assign limited benefits packages for each level. The



criteria are intended to provide a guideline for LMEs to use in approving person-centered plans. For example, if an individual is determined to meet the criteria for level II and their person-centered plan calls for services in a quantity that is in keeping with the benefit package, the plan does not require further review before approval. If a plan outlines less service, or more, than the benefit guidelines, the reviewer would more closely examine the explanation for the variances within the plan and determine if there was sufficient justification to approve the plan or if more documentation would be required. The criteria and benefit packages are not to be construed as absolute limits on services, but are instead guidelines for use by reviewers to begin to assess the appropriateness of an individual's planned level of supports.

A package which included the draft of proposed new waiver service definitions, a draft of the proposed new Medicaid State Plan definition, Developmental Therapies, and the UR criteria and accompanying benefit packages was shared with the Division External Stakeholders Group on June 12.<sup>th</sup> Review of the information and discussion is scheduled for the July meeting of the Group.

### **Systems Needs: Dialog and Products**

There are a number of critical areas that need to be addressed during this transitional year. Many of these also relate to overall reform-- such as the essential elements of person-centered planning (which includes guidelines for "needs" versus "wants"). Some of these are specific to the c waiver-- such as guidelines for managing aggregate funding. The Division SFY 03/04 Operational Plan identifies these areas that are to be developed, including as related to the c waiver. Developments will require dialog and input and result in direction, actions and/or products. This plan is dynamic as we can modify it as new issues are identified and new knowledge is acquired. The plan, which serves to operationalize State Plan 2003, will be available on the Division web site.

I look forward to working with you as we embark on this major challenge that stands before us.

RJV/lh

cc: Secretary Carmen Hooker Odom  
Lanier Cansler  
James Bernstein  
Executive Leadership Team  
Carol Duncan Clayton  
Sally Cameron  
Fred Waddle  
Patrice Roesler  
Connie Cochran  
Jill Keel  
Dave Richard



