DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 **Delaware Code**, Section 512 (31 **Del.C**. §512)

FINAL

ORDER

Acquired Brain Injury (ABI) §1915(c) Home and Community-Based Services Waiver Application

Nature of the Proceedings

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance submitted an Acquired Brain Injury (ABI) §1915(c) Home and Community-Based Services (HCBS) Waiver application to the Centers for Medicare and Medicaid Services (CMS). The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the October 2007 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2007 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposal

Statutory Authority

- Social Security Act §1915(c), *Provisions Respecting Inapplicability and Waiver of Certain Requirements of this Title*
- 42 CFR §441, Subpart G, *Home and Community-Based Services Waiver Requirements*

Background

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in accordance with §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

Summary of Proposal

This waiver will provide services for individuals aged 18 and above who have sustained an acquired brain injury (ABI) and who would otherwise require care in a nursing facility.

The goal of the waiver is to provide services to persons with ABI in a manner which responds to each consumer's abilities, assessed needs, and preferences, and which ensures maximum consumer self-sufficiency, independent functioning, and safety. This goal will be accomplished through the delivery of a range of home and community-based long-term cares services.

Services to be provided through the waiver include:

- Case Management
- Personal Care
- Adult Day Services
- Respite
- Cognitive Services

- Day Habilitation
- Personal Emergency Response System
- Assisted Living

The waiver will be administered by the Division of Medicaid and Medical Assistance (DMMA), the State Medicaid agency, and operated by the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). The waiver period is December 1, 2007 through November 30, 2010.

The provisions of this waiver are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Summary of Comments Received with Agency Response

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows.

As background, SCPD has been very involved in development of an ABI waiver. In the past, DHSS had secured CMS approval of an ABI waiver which it later abandoned based on an inability to secure providers. DHSS then attempted to have existing waivers amended to address the specific needs of persons with ABI. This initiative was abandoned in the Spring based on CMS lack of receptivity. Since then, DHSS has worked on development of a new ABI waiver. The SCPD has offered technical assistance to support renewed development of the waiver which will be effective December 1, 2007. The Councils have the following observations.

First, the overall program is "provider-based" and adopts a commercial-provider services model. Unlike the attendant services program, participant direction of services is not an option. [Application: 5; Appendix E-1:1] Since the services are more varied than attendant services, there may be some justification for adopting this approach in the initial 3-year waiver period.

Agency Response: Yes, because of the more varied service complement under the ABI Waiver, it was decided that the provider model would be used for the initial 3-year period.

Second, some positive aspects of the waiver include consumer choice of providers [Application: 8; Appendix B-7:1] and an individual service plan which covers wrap-around services, not simply those under the waiver program [Application: 7; Appendix D-1:4].

Agency Response: Comment noted.

Third, there is an MOU between DSAAPD and DMMA, signed in July of 2007, which describes agency collaboration in implementing the waiver. [Appendix A: 1; Appendix H: 3]. SCPD and GACEC respectfully request a copy of the MOU.

Agency Response: Both Councils will be provided with a copy of the MOU.

Fourth, the quality assurance system is relatively strong in the context of number of cases reviewed. A DSAAPD nurse will review 100% of initial case plans. [Appendix A: 4; Appendix D-1:7]. DMMA will conduct retrospective review of 25% of ABI care plans. [Appendix A: 2; Appendix D-1:7]. The latter review will be a "desk audit to ensure completion in accordance with all applicable ABI policies and procedures." Nurses will meet participants and review records of participants in AL facilities 3-4 times/year. [Appendix G-3:2] The weakness with this system is its lack of consumer surveys akin to the attendant services program. Reviewing paperwork will not result in identification of some deficiencies and diminishes the importance of consumer views of the responsiveness of the program to their needs.

Agency Response: The process described above is only one aspect of the comprehensive quality assurance system built into this waiver program. Case managers, who will have monthly, in-person contact with participants, will play a primary role in identifying deficiencies and discussing participant needs on an ongoing basis. Case managers will communicate these issues to DSAAPD through quarterly reports.

Fifth, although there is a minimum age limit (age 18), there is no maximum age limit. [Appendix B-1:1. The Councils endorse this provision since many of the individuals in the [Elderly & Disabled] E&D waiver will be elderly.

Agency Response: Thank you for the endorsement.

Sixth, there is a problematic statement at Appendix B-1:2. DMMA recites as follows:

The ABI Care Plan for participants in the waiver must demonstrate that the ABI waiver participant would benefit from ABI case management and at least one other ABI waiver services...<u>that are not available in another waiver</u>.

[emphasis supplied]. This may be an unnecessary restriction. It means that a person living outside an assisted living setting who seeks only personal care, respite, and a personal emergency response system would not qualify for the ABI waiver.

Agency Response: It is correct that the person described in your example would not qualify for the ABI Waiver. Because of the limited number of slots available, this waiver is designed to serve persons who would most benefit from its additional supports. The person described in your example would be encouraged to apply for services under the Elderly and Disabled (E & D) Waiver.

Seventh, apart from the requirement that a waiver participant meet a nursing level of care [Application: 2; Appendix B-6:2], DMMA imposes a severity test. A participant must "have a rating of at least 5 but not greater than 8 on the Rancho Los Amigos Level of Cognitive Functioning Scale. Attached is a copy of the Scale. One could argue that a person at Level IX could still benefit from waiver services.

Agency Response: Again, because of the limited space available in the waiver program, decisions were made to target those persons who could most benefit from the services provided.

Eighth, an aggregate rather than an individual cost cap is used in this waiver. [Appendix B-2:1; Appendix C-4:1]. The Councils endorse this provision.

Agency Response: Thank you for the endorsement.

Ninth, in the first year, up to 50 individuals may participate in the waiver. This would increase to 60 individuals in Year 2 and to 70 individuals in Year 3. [Appendix B-3:1] There is no prioritization based on current institutionalization, applicants in crisis, or geographical location. [Appendix B-3:2] If the waiver reaches capacity (50 persons in Year 1), a waiting list would be developed. First priority for the waiting list would be given to E&D and AL waiver participants. Second priority for the waiting list would be given to non-participants in the E&D and AL waivers. There is obviously a "cost" aspect to this prioritization since the State will spend less by transferring persons in an existing waiver to a new waiver. However, DHSS could consider whether some variation of this prioritization would be preferable. For example, if an individual with TBI is homeless and "in crisis", it may make sense to prioritize such an individual over someone receiving supports under an existing waiver. Alternatively, this population could be identified as a priority under the "second priority" criteria which is provided to non- participants in the E&D and AL waivers.

Agency Response: Given the fact that the demand for the waiver program is expected to exceed available slots, decisions were made with respect to service priority. It was decided to give preference to those persons on existing waivers who have been awaiting the ABI services. The ABI waiver is a long-term care program and is not designed for crisis alleviation. It is expected that, in such cases, efforts will be made to find appropriate placement for persons with immediate need for services.

Tenth, financial eligibility is limited to individuals with countable income under 250% of the federal benefit rate (FBR). [Appendix B-4:2] Consistent with the attachment, the FBR for an individual in 2007 is $623 and 250% of the FBR would be $1,557.50. The Councils recommend that DMMA adopt a 300% of FBR standard which would equate to $1,869/month in countable income.

Agency Response: The income limit will stand at 250% of FBR.

Eleventh, DMMA requires a participant to require at least 1 waiver service apart from case management on a monthly basis. DMMA did not adopt the option of "monthly monitoring of the individual when services are furnished on a less than monthly basis". The problem with this approach has been debated in the context of the DD waiver. Under that waiver, individuals who are very elderly (80), recovering post-hospitalization, or diagnosed with cancer with 4 months to live still must attend a day program or lose waiver eligibility. If an ABI waiver participant cannot attend Enhanced Level II day services or day habilitation due to illness or other cause, DMMA unnecessarily restricts its discretion to maintain the person's waiver eligibility.

Agency Response: Persons who do not meet the criteria for the ABI Waiver may be provided with services under another funding source, such as the Elderly & Disabled Waiver or the Assisted Living Waiver.

Twelfth, the menu of services is as follows: 1) case management; 2) personal care; 3) adult day health; 4) day habilitation; 5) respite; 6) day treatment (cognitive treatment); 7) personal emergency response system; and 8) assisted living. [Appendix C-1:1] The scope of some of these services is not intuitive. For example, the waiver does not cover room and board for assisted living. [Appendix C-2:3] Rather, it covers only the cost (approximately $37.17 to 64.76 daily) of some enhanced services. [Appendix I-2:1; Appendix J-2:2; Appendix J-2:7] As a practical matter, this may exclude participation in the waiver by many assisted living residents. Query how many individuals will be financially able to pay approximately $36,000 for assisted living base costs when they can only have countable income of 250% of the FBL ($1,557.50)? Moreover, many AL facilities already provide the contemplated enhanced services, including "prompting". [Appendix C-3:3]. See, e.g., attached rate levels for sample AL facility (Somerford). Forty percent (40%) of waiver participants are expected to receive AL services. [Appendix J-2: 2] DMMA suggests that State funds might be used for room and board, but it is unclear if such funds are included in the DHSS budget. [Appendix I-5:1]

Agency Response: First, room and board costs in assisted living cannot be paid for under a waiver program. Because of income restrictions for eligibility in a waiver program, participants are not expected to have incomes sufficient to cover these costs. Most participants in a waiver program are also eligible for SSI and/or the SSI State Supplement, which are used to pay for room and board. With regard to additional costs for providing "prompting" and other services, this enhanced rate is available because of the increased staff attention needed by some persons with acquired brain injuries.

Thirteenth, DMMA had the option of allowing relatives to provide waiver services. However, it did not exercise this option for any service. [Appendix C-2:4; Appendix C-3:3; Appendix C-3:7; Appendix C-3: 11; Appendix C-3:13; and Appendix C-3:15]. This is objectionable. At least in the contexts of respite and personal care services, relatives should be authorized providers. Compare attached DDDS respite policy, which recites as follows:

> O. Natural families may identify a family member or other individual (at least 18 years of age) whom they feel is appropriate to provide private respite for their family member. It shall be the responsibility of the family to insure that the said private provider is competent to provide adequate support to ensure the individual's health and safety.

Moreover, DHSS recently amended its attendant services program policy to authorize payment of relatives. See attached email which resulted in policy change during summer.

Agency Response: As noted in the response to comment #1, the decision was made for the initial 3-year period of this waiver to operate the program using a provider model. It is recognized, however, that consumer direction, including the use of family members to provide care, has clearly demonstrated merit as a service delivery model.

Fourteenth, case management can only be provided by an RN or LCSW. [Appendix C-3:1] This should enhance the quality of services plans. Many organizations use case managers with only a bachelor's degree.

Agency Response: These credentials are important because of the complex nature of the issues and service needs of the ABI population.

Fifteenth, the waiver includes utilization limits. Some of these limits are odd. For example, the limit for both adult day services and day habilitation is 4 days per week. [Appendix C-3:5; Appendix C-3:7] It is inferable that most individuals attending day programs attend 5 days/week. Exceptions are allowed based on case manager requests. Id. In this sense, the limits are more akin to "guidelines". However, it would make sense to establish a guideline of participation in day services and day habilitation of 5 days/week. In the context of "cognitive services" [Appendix C-3:9], DMMA may similarly wish to upgrade the 20 visits/year limit. This equates to only 1.66 counseling visits per month. Other questionable limits apply to personal care services (14 hours/week)[Appendix C-3:11]; and respite (80 hours/year)[Appendix C-3:13]. Parenthetically, the limits may have been set somewhat low to reduce projected costs.

Agency Response: These limits were based on an analysis of utilization patterns of participants in existing waiver programs. The limits were also established to maintain costs based on the need for cost neutrality and on the availability of State funds in support of the program.

Sixteenth, DMMA recites that the aggregate cost cap is based on "both waiver services and other services." [Appendix C-4:1]. This may not be 100% accurate. Services which are "private pay" or derived from non-Medicaid sources should not be included in the aggregate cap. The expected per participant cost in Year 1 is expected to be $6,901. [Appendix C-4:2]

Agency Response: In this context, "other services" refers to services paid for under the Medicaid State Plan.

Seventeenth, DMMA limits case management to agencies which do not provide services under the individual client plan. [Appendix D-1:1] This reduces the prospects for conflicts of interest in which the case manager "loads up" the plan with its own services. On the other hand, it limits the potential role of a TBI specialty provider which could otherwise offer both an LCSW case manager and counselor.

Agency Response: This limitation was established to reduce the possibility of conflict of interest among case management providers.

Eighteenth, the ABI care plan must include back-up plans in the event the regular provider becomes unavailable. [Appendix D-1:6]. The Councils endorse this provision.

Agency Response: Thank you for the endorsement.

Nineteenth, case managers must meet "in-person" with participants at least monthly. [Appendix D-2:1; Appendix D-2:2] The Councils endorse this provision, but also recommends that meetings be at the location where services are being provided.

Agency Response: Case managers will have the discretion to meet at locations which are agreed upon by both the participant and the case manager.

Twentieth, DSAAPD will refer persons who request a fair hearing to the Community Legal Aid Society, Inc. for assistance. [Appendix F=1:1] The Councils endorse this provision.

Agency Response: Thank you for the endorsement.

Twenty-first, the use of seclusion or restraint is expressly prohibited. [Appendix G-2:1] The Councils endorse this provision.

Agency Response: Thank you for the endorsement.

Twenty-second, DMMA incorrectly recites that administration of medication is limited to medical personnel or personnel who have completed Board of Nursing training. [Appendix G-3:3]. This ignores a participant's right to self-administer medications; the participant's right to delegate administration to others consistent with Title 24 **Del.C.** §1921(a)19); and the right of relatives, friends, housekeepers, and servants to administer medications consistent within Title 24 **Del.C.** §1921(a)(4). See also Title 24 **Del.C.** §1921(a)(18)[Nurse Practice Act not applicable to attendants acting pursuant to Attendant Services Act].

Agency Response: You are correct that there are exceptions to the Nurse Practice Act which allow non-medical personnel to administer medications. The response provided in this section of the application refers to the requirements under the Act as they apply to providers of services available through the waiver.

Twenty-third, estimated costs of the waiver services are compiled at Appendix I-2 and Appendix J-2. Reimbursement rates for some services are actually somewhat high, i.e., respite is $26.68/hour and personal care is 30.32/hour. This may be a function of the commercial provider bias inherent in the waiver. Note that rate increases may be deferred if State appropriations are insufficient. [Appendix I-2:1]

Agency Response: Cost estimates were based on reimbursement levels in existing waiver programs along with projected costs for providing comparable services to the ABI population.

Twenty-fourth, DMMA recites that the "State does not make supplemental or enhanced payments for

waiver services." [Appendix I-3:2] This appears inconsistent with references to payments for supplemental services or additional reimbursement throughout the application. [Appendix C-3:3; Appendix C-3:5]

Agency Response: It appears that there is some confusion surrounding the terms "supplemental" and "enhanced." In Appendix I, it is correctly stated that Delaware will not make supplemental or enhanced payments. This means, essentially, that the State will not pay additional amounts above the agreed-upon rates. (An example of such a payment is a performance incentive.) Some of the services, such as assisted living, have built-in "enhanced" (or Level 2) rates, meaning that there is an agreed-upon higher level of reimbursement for this level of service. This is a fixed rate, not an add-on as defined in Appendix I.

Finally, the Division anticipates negligible turnover in waiver participants. This is ostensibly a realistic prediction. [Appendix J-2: 1]

Agency Response: Comment noted.

Findings of Fact

The Department finds that the proposed changes as set forth in the October 2007 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation related to the Acquired Brain Injury (ABI) §1915(c) Home and Community-Based Services Waiver application is adopted and shall be final effective December 10, 2007.

Vincent P. Meconi, Secretary, DHSS, November 14, 2007

An authenticated PDF version of the Acquired Brain Injury (ABI) §1915(c) Home and Community-Based Services Waiver Application is available here:

http://regulations.delaware.gov/register/october2007/proposed/waiver.pdf Waiver