Minnesota Governor's Council on Developmental Disabilities
Department of Administration

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February 2, 2000

To: Public Policy Members, Governor's Council on Developmental Disabilities

From: Pat Tietz, Public Policy Chair

Re: Michigan and West Virginia waiver sections

The following documents are two examples of states (West Virginia and Michigan) that are allowing parents to direct Medicaid resources spent on their children with disabilities.

We will continue to try to obtain information from other states that are successful in billing Medicaid for such services and pass that information onto you as well.

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MDCH/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT: INDEX

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NOW, THEREFORE, in consideration of the above, and in consideration of the promises and mutual covenants hereinafter contained, the parties hereto agree as follows:

2.0 PREAMBLE

It is the intent that the CMHSP and the MDCH pursue all decisions and actions in the execution of this Contract consistent with the fundamental values as stated below. A violation of the preamble does not constitute a breach of contract.

* The quality and array of supports and services are to be provided in a like manner to all priority populations.

* The design and delivery of mental health supports and services will support consumer self-determination and independence.

* Supports and services will be of high quality, cost-effective, and nondiscriminatory.

* All supports and services will be provided in a manner that demonstrates cultural competency.

* Those with the greatest need (i.e., the persons with severe impairments and/or those most at risk) will be appropriately served as first priority.

* The rights of individuals will be preserved and protected.

* Consumers and families will have a meaningful and valued role in the design, service delivery and evaluation of the CMHSP.

* Consumers will be empowered to guide their own supports and services planning and provided reasonable choices of supports and services.

* Efforts to maintain and further expand consumer-operated and controlled alternatives will be pursued.

* Partnerships will be continuously developed in the community with an intention of increasing the community's desire and capacity to support and accommodate people with disabilities and their families.

* Prevention activities that serve to inform and educate persons will be carried out with the intent of reducing the risk of severe dysfunction.

* Collaborative relationships, which may include shared funding arrangements with other community agencies with a shared population, will be promoted.

* Community-based rehabilitation, recovery and inclusion into community life will be promoted.

* Public funds will be expended in a manner that is legal, prudent, and ethical.

* Management of existing resources will continually improve by moving away from high cost, highly structured and regulated service models to more individualized, cost-effective services and supports for consumers, which may include options for consumer-directed or managed services and supports.

* Savings generated through increased efficiencies will be reinvested into systems, supports and services as determined by the CMHSP consistent with the policy directions of the MDCH.

In the event that either party has reason to believe that the other is acting in a manner that conflicts with these mutually agreed upon principles and values, such party may request a meeting to discuss said concerns.

3.0 GENERAL PROVISIONS

The MDCH and the CMHSP agree to the general provisions stated in the following subsections.

3.1 DEFINITIONS

The terms used in this Contract shall be construed and interpreted as defined in the attachment **(Attachment 3.1.1)** to this Contract.

3.2 PARTIES AND PURPOSE

The MDCH and the **NAME OF THE CMHSP** (CMHSP) agree to the provisions of this Contract for the purpose of ensuring the provision of services to identified populations according to standards and policies as specified in this Contract.

3.3 AUTHORITY

This Contract is entered into under the authority granted by 116 (2) (b) and (3) (e) and Section 228 of Act 258 of the Public Acts of 1974, as amended. Provisions of that Act, all rules promulgated and adopted under that Act and applicable state and federal laws shall govern the expenditure of funds and provision of supports and services.

3.4 RELATIONSHIP

This is a contract between the MDCH and the CMHSP. The MDCH is recognized as the funder and the CMHSP as the contractor in this contractual arrangement.

(e) Diagnoses (mental and physical)

(f) Cause of death

(g) Recent changes in medical or psychiatric status, including notation of most recent hospitalization

(h) Summary of condition and treatment (programs and services being provided to the consumer) preceding death

(I) Any other relevant history

(j) Autopsy findings if one was performed and available

(k) Any action taken as a result of the death

4. Should additional statistical or management information from data currently collected by the CMHSP be required by the MDCH, at least forty-five (45) days written notice shall be provided. The written request shall identify who is making the request as well as the purpose of the request. The MDCH shall make earnest efforts not to request additional information (above and/or beyond what is required in this Contract and/or any modification of the contract informational requirements). Particular exceptions include additional informational requirements issued by funding and regulatory sources and/or resulting from legislative action.

5. The MDCH agrees to notify the CMHSP of any requests for information from data supplied to the MDCH by the CMHSP.

4.8 VOUCHERS

1. Vouchers issued to consumers for the purchase of services provided by professionals may be utilized in non-contract agencies that have a written referral network agreement with the CMHSP that specifies credentialing and utilization review requirements. Voucher rates for such services shall be predetermined by the CMHSP using actual cost history for each service category and average local provider rates for like services.

2. Voucher arrangements for purchase of consumer-directed supports delivered by nonprofessional practitioners may be through a fee-for-service arrangement.

3. The use of vouchers is not subject to the provisions of Section 4.7.6.1 (Procurement) and Section 4.7.6.2 (Subcontracting) of this Contract.

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4.9 COORDINATION

The following subsections describe coordination arrangements required by this Contract. If any of the arrangements described in Sections 4.9.1 through 4.9.7 (inclusive) are not secured, the CMHSP shall notify the MDCH and continue to demonstrate a good faith effort to secure the arrangement(s).

4.9.1 Health Plans (HP)

Joint coordination/collaboration agreements shall be developed and maintained between the CMHSP and each Health Plan (HP) in its service area. A copy of the CMHSP/HP model agreement for Behavioral Health and a copy of the CMHSP/HP model agreement for Developmental Disabilities are attached to this Contract **(Attachment 4.9.1.1 - A and B)**. The CMHSP may develop and maintain a single joint coordination/collaboration agreement for both Behavioral Health and Developmental Disabilities as long as the substantive requirements for both agreements are included in the single agreement.

4.9.2 Multi Purpose Collaborative Body (MPCB)

The CMHSP shall be a signatory to the Multi Purpose Collaborative Body (MPCB) collaborative agreement and actively participate as a member of the MPCB.

4.9.3 Schools/Intermediate School Districts (ISD)

The CMHSP shall develop with the Intermediate School District (ISD) a local memorandum of understanding specifying responsibilities and methods of communication in the coordination and non-duplication of services.

4.9.4 Jobs Commission

The CMHSP shall work with the Michigan Jobs Commission - Rehabilitation Services (MJC-RS) district offices regarding the relative roles and responsibilities of the parties in the provision of rehabilitative services. Any agreements shall be based upon a statewide model and shall include, at a minimum, procedures for assuring that federal Medicaid funds are not being used to replace services that are the responsibility of the Vocational Rehabilitation system.

4.9.5 Family Independence Agency (FIA)

The CMHSP shall develop, with the Family Independence Agency (FIA), a local memorandum of understanding specifying responsibilities and methods of communication in the coordination and non-duplication of services and collaboration between the two agencies.

HCFA MANUAL

B. Consi... to Specific Services.--

1. FFP is not available for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses or parents of minor children, when the services are those that these persons are already legally obligated to provide.

2. Services provided by relatives or friends, except as noted in item B.1., may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers ... of specific services rendered, and there is adequate justification as to why the relative or friend is the provider of ca... e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such ... are not already legally obligated to provide.

3. Prevocational, educational or supported employment services may not be provided under the waiver other than as part of habilitation ... as defined below.

Effective ... October 7, 1986 until October 1, 1997, you may include in your definition of habilitation services furnished to individuals who have been discharged from a NF or ICF/MR prevocational, educational, and supported employment services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully outside an institution. Effective October 1, 1997, expanded habilitation applies to any eligible individual that the State determines requires the expanded habilitation services. The legislative requirement that an individual be discharged from an NF or ICF/MR has been deleted. States may, however, continue to include the discharge requirement for the expanded habilitation services noted above.

a. Prevocational services are services aimed at preparing an individual for paid or unpaid employment but which are not job task oriented. ... could include teaching a client such concepts as compliance, attending, task completion, problem solving and safety. They are aimed at a more generalized result. In distinguishing prevocational services coverable under a waiver from noncoverable educational services, consider the following criteria. Prevocational service activities:

o Are provided to individuals who are not expected to be able to join the general work force or participate in a transitional sheltered workshop within 1 year (excluding supported employment programs),

o If compensated, are compensated at less than 50 percent of the minimum wage,

o Include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (e.g., attention span, ... skills), and

o Are reflected in the plan of care directed to habilitative rather than explicit employment objectives consonant with the aims outlined in the preceding criteria.

b. Educational services are special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act) (Public Law 94-142) (20 U.S.C. 140(16) and (17)) to the extent they are not prohibited under §4442.3.

c. Supported employment is paid employment which

o Is for persons for whom competitive employment at or above the minimum wage is unlikely and who, because of their disabilities, need intensive ongoing support to perform in a work setting;

o Is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed; and

o Is supported by any activity needed to sustain paid work by persons with disabilities, including supervision, training and transportation.

d. Habilitation services do not include special education and related services (as defined in §4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a

NEWSLETTER

HCFA Widens Consumer-Directed Personal Care Options

In October, the Health Care Financing Administration (HCFA) issued additional revisions to its **State Medicaid Manual** materials concerning personal care services. The revisions are contained in State Medicaid Manual transmittal number 73. In January 1999, HCFA substantially revised and reissued the Manual materials concerning personal care (see ***Perspectives***, May 1999 for more detail).

Background. In the Omnibus Budget Reconciliation Act of 1993, Congress added a section to the Social Security Act formally recognizing that states could offer personal care services under their state Medicaid plans. Under prior law, coverage of personal care had been allowed under the Secretary's authority to add services not specifically spelled out in the Act. In making the addition, Congress intended to give states more flexibility in providing personal care services under their state Medicaid plans. Specifically, Congress authorized the provision of such services outside a person's residence and eliminated the requirement that services be prescribed exclusively by physicians. In 1997, HCFA updated its regulations to reflect the 1993 provisions.

The latest revision makes it clear that consumer directed personal care services may be furnished to any individual who has the ability and desire to manage their own care. The January 1999 materials had limited the provision of consumer directed personal care services to individuals who are not cognitively impaired and thereby seemed to preclude people with mental retardation and other developmental disabilities from utilizing such services.

The October 1999 revision also provides that consumer directed personal care services may be furnished through the use of "surrogates" (e.g., family members or other individuals). Specifically, the revised Manual materials concerning consumer-directed services now read:

> Consumer-Directed Services – A State may employ a consumer-directed service delivery model to provide personal care services under the personal care optional benefit to individuals in need of personal assistance, including persons with cognitive impairments, who have the ability and desire to manage their own care. In such cases, the Medicaid beneficiary may hire their own provider, train the provider according to personal preferences, supervise and direct the provision of personal care services and, if necessary, fire the provider. The State Medicaid Agency maintains responsibility for ensuring the provider meets State provider qualifications ... and for monitoring service delivery. Where an individual does not have the ability or desire to manage their own care, the State may either provide personal care services without consumer direction or may permit family members or other individuals to direct the provider on behalf of the individual receiving services.

While these provisions concern personal care services furnished as a Medicaid state plan service, they also can be applied to home and community-based waiver programs.

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provider in person-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the residential habilitation provider must be provided by professional staff (ie. QMRP Level I, II, III, RN, Special Education instructor).

Up to 1 of hour residential habilitation may be charged by the Residential Habilitation service provider to participate in the development of the annual IPP and another 1 hour may be charged to participate in the 6-month IPP review. Billing may occur only for program planning meetings outlined above .

B. **LOCATION OF SERVICE** - Residential Habilitation is provided in the following settings:

1. The participant's own home or apartment;

   The Service Coordination agency or the behavioral health center which is responsible for delivering Residential Habilitation is also responsible for assisting the individual in choosing a safe residence or teaching the person how to improve or change his/her residence if it is unsafe. **Residential Habilitation services may not be delivered in a residence which endangers the health or safety of the participant or the staff;**

2. Biological and adoptive family homes;

3. Specialized Family Care Homes certified by the Specialized Family Care Program administered by The West Virginia University Affiliated Center for Developmental Disabilities (UCADD) and Department of Health and Human Resources, Office of Social Services (O.S.S.);

4. Group homes licensed by the Office of Health Facilities Licensure and Certification (OHFLAC) to serve individuals with mental retardation and/or developmental disabilities; or

5. Individualized Support Settings (I.S.S.) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities.

   Residential Habilitation services may also be carried over in the necessary local public community environments which will facilitate increasing or maintaining the individual's independence in his/her residence as outlined

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Biological and adoptive parents and SFCPs may only deliver the service of **Community Residential Habilitation** to their own children and family members.

The MR/DD Waiver Program is <u>not</u> an entitlement program and Residential Habilitation is <u>not</u> a family stipend.

If the Interdisciplinary Team (IDT) decides that a biological or adoptive parent, or a family member may be a good choice for a Residential Habilitation provider, the IDT chooses him/her to provide Community Residential Habilitation under the following conditions:

- The Service Coordination agency or behavioral health center which is responsible for providing Residential Habilitation services has attempted to, and been unable, to recruit a trained and qualified provider who is not a family member;

- The parent or family member meets the MR/DD Waiver Program's and the agency's training and educational qualifications for Residential Habilitation service providers. Training is provided by professional staff prior to implementation of services, and be documented on the DD-13 form. This form is to be kept on file in the agency's provider file.

- The Service Coordination agency monitors the Residential Habilitation services, as it does all services, through monthly home visits and other contacts. The behavioral health center which is responsible for providing Residential Habilitation services arranges for or provides a QMRP who is responsible for <u>training</u> and <u>monitoring</u> to ensure the delivery of services in accordance with the IPP.

The conditions listed above allow the MR/DD Waiver Program to meet the following federal regulations: "Services provided by relatives or friends may be covered only if the relatives or friends meet the qualifications for providers of care, there are strict controls to assure that payment is made to the relative or friend as providers only in return for specific services rendered, and there is adequate justification as to why the relative or friend is the provider of care, e.g., lack of other qualified providers in remote areas." (HHS/HCFA Medicaid Manual, Part 4, Transmittal #37, September, 1988, Regulation 4442.3 (B)(10)).

Participants who reside in Individualized Support Settings (ISS) or group homes may receive residential habilitation in the form of <u>assistance by staff</u> as they participate in activities at home or in the local community. This assistance

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provides the individualized support necessary for participation in the activity. Unlike residential habilitation training, this assistance is not presented in a training format with formal training objectives. Based upon evaluations, the IDT (1) determines if the individual requires assistance to participate in non-training residential activities; (2) identifies on the ISP those activities for which this support would be provided; and (3) specifies the amount of support (hours per month). Residential habilitation assistance is to be provided in combination with daily residential habilitation training. A participant must have a current residential training program to qualify for the residential habilitation assistance. Documentation of residential habilitation assistance is to be maintained as described in the documentation section of Residential Habilitation.

A maximum of 8 hours per day of monitoring and supervision may be provided to a participant. The need for monitoring and supervision must be supported by evaluations and included in the IPP. Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions. **Monitoring and supervision in a family home or a Specialized Family Care Home (SFCH) may not be provided by a family member or the Specialized Family Care Provider (SFCP) and requires an explanation of why the family supports are not available to the participant.**

Special permission is required to provide monitoring and supervision for more than 50% of the Residential Habilitation services billed on a daily basis.