

**MEDICAID AND ELDER JUSTICE**  
**Wednesday, September 9, 2010**  
**North Carolina Institute of Medicine, Morrisville**  
**1:00-4:00**

*Workgroup Members:* Craigan Gray (co-chair), Steve Wegner (co-chair), Jon Abramson, Mary Bethel, Sherry Bradsher, Missy Brayboy, Deborah Brown, Steve Cline, John Eller, Abby Carter Emanuelson, Johnnie Farmer, Ted Goins, Richard Gottlieb, Joe Holliday, Richard Hudspeth, Rep. Verla Insko, Laketha Miller, Lydia Newman, Carla Obiol, Carla Pellerin, Sen. William Purcell, Kathie Smith, Dennis Streets, Curtis Venable, Tom Vitaglione, Chuck Willson, Leonard Wood.

*Steering Committee members:* Trish Farnham, Tara Larson, Julia Lerche, Sabrena Lea, Carolyn McClanahan, Larry Nason

*Staff:* Pam Silberman, Berkeley Yorkery

*Interested Persons:* Chip Baggett, Kari Barsness, Judy Brunger, Melanie Bush, John Dervin, Lee Dixon, Mary Edwards, Kerri Erb, Anna Lore, Jan Lowery, Peyton Maynard, Ben Popkin, Chris Skowronek, David Swann, Rebecca Whitaker

**Welcome and Introductions**

*Craigan Gray, MD, JD, MBA*

*Director, NC Division of Medical Assistance*

*North Carolina Department of Health and Human Services*

*Steve Wegner, MD*

*President*

*NC Community Care Network*

*Access Care, Inc.*

Dr. Gray welcomed everyone and asked everyone in the room to introduce themselves. He also reminded people that while the state is under significant budgetary constraints today, that we also need to consider longer term options available to the state as part of the Affordable Care Act.

**Discussion of Home and Community Based Services (HCBS)**

**Larry Nason, EdD**

Chief of Facility and Community Care

Home and Community Services

Division of Medical Assistance (DMA)

NC Department of Health and Human Services

Dr. Nason discussed the state's existing home and community based Medicaid waivers for frail older adults or people with physical disabilities (Community Alternatives Program for Disabled Adults, or CAP/DA), and for medically fragile children (CAP/C). He noted that the state is

beginning to develop CAP choice opportunities, whereby individuals can manage their own CAP funds, and hire and fire their own personal care workers. He also discussed other programs available to serve older adults or people with disabilities in their homes, including in-home personal care services, the Program for All-inclusive Care for the Elderly (PACE), and private duty nursing. Dr. Nason described how the waiver program services have been cut in recent years because of the budget shortfall. He described some of the changes that DMA is making to personal care services and private duty nursing to comply with federal Medicaid laws for children, and at the direction of the NC General Assembly. Dr. Nason also discussed new home and community based service options available under the Affordable Care Act, including Community First Choice option, removal of barriers to home and community based services, and the rebalancing program. The Community First Choice option provides a 6 percentage point increase in the federal medical assistance percentage (FMAP) match rate to the state for home and community based services provided to people who would otherwise need institutional level care. The Rebalancing Initiative provides a 2 percentage point increase in the FMAP rate. Click here for more information: [Home and Community Based Options](#).

**Judy Walton, MSW**

Waiver Development Chief  
Division of Medical Assistance  
North Carolina Department of Health and Human Services

Ms. Walton discussed DMA's plans to submit a 1915(i) waiver to the federal government. She noted that North Carolina has traditionally provided personal care services to individuals in adult care homes as a regular Medicaid-covered service. However, the federal Centers for Medicare and Medicaid Services (CMS) was pushing North Carolina to find an alternative way to pay for these services. The Medicaid 1915(i) waiver is a way to provide these home and community based services to individuals in an adult care home. Under the prior 1915(i) provisions, the state could only designate one target population to serve. As part of the ACA, states now can designate more than one target population to serve with additional home and community based services. So, while the state is still planning on submitting its waiver application to target people in adult care homes, DMA could potentially expand the target population to include additional groups in the future. The major difference between the 1915(i) waiver and other waivers is that 1915(i) is an entitlement to individuals who meet the program rules. In contrast, the state can limit the number of people it serves through the 1915(c) waivers (the governing authority for the CAP/DA and CAP/C programs). Thus, there is increased financial risk to the state by opening the 1915(i) waiver up too broadly.

**Trish Farnham, JD**

Money Follows the Person Director  
Division of Medical Assistance  
North Carolina Department of Health and Human Services

Ms. Farnham described the Money Follows the Person (MFP) program. This program provides enhanced federal funding to enable people who currently reside in institutions to move back into a community setting. In order to qualify for the enhanced MFP funding, the person must be a qualified individual who resided in a qualified inpatient facility (nursing facility, ICF-MR, state

developmental center, or hospital) for at least three months, and who moves to a qualified residence in the community. A qualified residence is one that is a home owned or leased by the individual, or an apartment with an individual lease, or a community based setting with no more than four unrelated individuals. The federal government will pay enhanced funding for up to a year, and will pay for services that would not otherwise be covered (such as rent deposit). To date, the state has been able to transition 51 individuals from institutional to community settings through MFP, but expects to be able to grow the program in the future. Click here for more information: [Money Follows the Person](#).

*Selected questions/comments:*

- Q: What type of control do you have over the quality of the services provided in the community for the MFP program?  
A: The transition coordinator and care managers are responsible for ensuring that services are being provided and the quality of the services being provided. In addition, providers still have to meet the existing quality standards required for all Medicaid providers. One option the state could consider is to provide enhanced monitoring for people in the MFP program, if the group thought this was a group that was particularly at-risk.
- Q: Could the MFP program be manipulated? For example, could someone place someone into an institutional setting for three months in order to get the additional transition services?  
A: We do not know.

**FACILITATED DISCUSSION**

**Pam Silberman, JD, DrPH**

President and CEO

North Carolina Institute of Medicine

Dr. Silberman reminded the workgroup that they serve in an advisory capacity only, not as a decision making group. She noted that the workgroup might want to consider short-term and longer-term options. Click here to see Dr. Silberman's presentation: [Questions for the Workgroup](#). She asked the workgroup to consider three questions:

- 1) What additional information or data do you need to consider these options?
- 2) What are the potential advantages and disadvantages of the different federal options to expand home and community based services?
- 3) Are there ways to increase the quality and efficiency of existing home and community based services, so that we could serve more people within existing resources?

*General questions/comments:*

- Q: What are the overall goals that the state is trying to accomplish with these programs?  
**A: The workgroup generally agreed that the state's overall policy should be to support individuals in having choices that would enable them to live in the least restrictive setting appropriate to their needs.**

- Providing services in the least restrictive setting is a challenge, because there are not enough community services, including affordable housing, to support people in the community. Further, the existing community based services are not well distributed across the state.
- This issue is particularly problematic given recent budget cuts. Many of the existing home and community based service providers are under severe financial stress, and are cutting staff and services because of the budget cuts in the last few years. While there is a lack of affordable housing throughout the state; the problem for direct service providers is more due to the lack of payment support than the lack of providers willing and able to provide services.

Data needs:

- What is the cost of home and community based services (through CAP/DA, CAP/C, CAP/MR-DD, or MFP) vs. institutional care?
- Does the state have cost effectiveness data that factors in both the costs of caring for people in different settings, but also quality of life and other quality indicators?
- Who could potentially benefit if the state expanded home and community based services to more people (through the Community First Choice option, expansion of the 1915(i) waiver, or the rebalancing initiative?)
- How much would the state gain in enhanced FMAP funds through the Community First Choice option or Rebalancing Initiative if the state expands HCBS through either program option? We need to look at the net new costs to the state (ie, the new costs for program expansion, minus any new federal funds we receive from the enhanced FMAP rates). (Note: the state has still not received federal program guidance for these programs, so we do not yet know how CMS will calculate the enhanced funding available to the state through these programs).
- The group needs more information about who DMA serves through existing waiver programs (numbers, types of services), and available options through the 1915(i) program. Where could the state get the biggest “bang for the buck.”

Greater efficiencies in existing home and community based waiver programs:

- Q: Is there a way to support families who are currently caring for frail older adults or people with disabilities? Wouldn't it be cheaper to the state to support families than it would be to put people into institutional settings?  
A: The state could explore some of the waiver options to see if it could provide additional respite services to family members. In addition, the CAP-Choice option enables eligible individuals to manage their own CAP funds (to pay for services of friends, neighbors or certain family members). However, the state also needs to build in consumer protections to ensure that the frail elderly, or other people with intellectual or physical disabilities are not forced or coerced to hire family members or others.
- Q: Can we do a better job in targeting limited resources to those most in need? Does the state have a validated assessment instrument that will help identify a person's needs for services and supports, as well as other resources available through family or the community to meet those needs?  
A: The state is beginning to use an assessment tool for people with intellectual and other

developmental disabilities, called the Supports Intensity Scale (SIS) to accomplish this purpose.

- Q: Are there other programs the state could offer which could reduce the per-person cost of home and community based services? For example, adult day health programs?
- Q: If we expanded Medicaid to cover more people with home and community based services, could we free up existing state funds used to support these programs? Could these state funds be used to meet the state's Medicaid match for the new program expansion?
- Q: Could we save money to the state through greater coordination of services (for example, by coordinating care from acute hospital settings to the community)?

A: The ACA does include provisions to increase coordination between hospitals and community providers (ie, to reduce unnecessary readmissions).

#### Additional comments/questions about future work of the Medicaid workgroup

- Q: If the goal for 2014 is to simplify administration for the Medicaid program (in order to enroll more people), then should the state continue to operate two programs for children (Medicaid, and NC Health Choice)? Should we consider combining the public insurance programs for children?  
A: We can consider this issue at a future meeting. We need to look at the differences between the two programs.
- Q: What is the state currently spending money on? How much of the Medicaid funding is spent on what type of services?