

# Functional Assessment Workgroup – Meeting #1

1:30 – 3:30 PM

July 12, 2023

## Meeting Attendance

Organization	Representatives
Wichita State University Community Engagement Institute	Carri McMahon
N/A	Cassandra Sines
University of Kansas	Claudia Dozier
N/A	Connie Zienkewicz
Johnson County Community Developmental Disability Organization (CDDO)	Jade Graham
InterHab	Matt Fletcher
Sunflower	Nanette Perrin
Heartstrings	Rosanne Thiry
SDSI CDDO	Steve Sandoval
DPOK CDDO	Tara Cunningham
N/A	Teresa Beaudry
Kansas Department of Aging and Disability Services (KDADS)	Theresa Singh
Kansas Department of Aging and Disability Services (KDADS)	Jason Sheets

## Welcome/Introduction

Agreements Suggested:

The group added the following to the suggested meeting agreements:

- Spell out acronyms

Question:

- What is the timeline for implementation?
  - We'll get into the details soon, but we're anticipating the workgroups will finish their work by early September.

## Workgroup Background

Theresa & Jason shared information about the workgroup background and formation process.

Questions from the workgroup:

- Will there be review by CMS before implementation?
  - Yes, CMS has to approve everything before it's implemented.

## **Purpose & Resources**

Jason & Theresa shared information about this specific group's purpose and the resources provided and reviewed the regulation language together.

Questions from the workgroup:

- In the previous work group that we were in, MFEI was just supposed to be the holding place, it wasn't supposed to be the name of the assessment. Could we call it something other than the Medicaid functional eligibility instrument?
  - We can look at that, but for now, for simplicity, will use MFEI.
- How were the States chosen for comparison?
- KDADS selected the states, unsure of methodology. Theresa & Jason will follow up.
- Is this taking account into account discussions around a potential new waiver for those not needing extensive supports like residential services?
  - No, since we're only looking at the IDD Waiver and the other waiver is still in development.
- When there's a reference to tier or level of disability. Are we to assume that's done with the same functional assessment tool that they use for eligibility?
  - Believe so, but Jason/Theresa will check
- For the Community Support Waiver do we know if it would have the same functional and eligibility assessment?
  - No, we don't

## **Discussion**

### **What do you like or dislike about other states' funding structures?**

Parents/Family:

- Flat rate didn't make sense, based on varying needs of what people need for day/residential services. Should also consider accounting for extensive personal care needs. Ohio flat rate for individual employment support – vast difference for people who are seeking employment.
- Cost of doing business – how to calculate. Understand cost variance in Johnson County vs. far western Kansas. How does Ohio calculate cost of doing business?
- Several states use tiers or similar.

#### Advocates:

- Similar discussion to parents
- Beyond flat rate- there are needs beyond medical / behavioral needs that require additional support
- Ohio – cost of doing business; not enough information to know if this is good/bad.
- MFEI – discussion of what it is/what it entails/how to use?
- Would like more detail in the rate and funding report.
- Make sure individuals are held harmless in any transition.

#### Provider/MCO:

- Same as other groups.
- Like regional differential.
- Ohio system was complicated.
- No state had funding for ADL or behavioral health needs.
- What functional assessment do other states use?

#### CDDO:

- Intrigued by flat rate, concerned with it being adequate.
- One size doesn't fit all, concerned about regionalization if it would capture true cost.
- Like exception process for higher levels of needs
- Assessment can be subjective – capturing ADLs accurately.

#### Are any states doing it well?

- No – need more information.
  - What assessment do they use?
  - How do they determine extraordinary funding?
    - Who does the extraordinary funding assessment?
    - Is it a different tool from eligibility?
- Like consideration of cost of doing business. Kansas didn't make changes for a long time and needs a plan for upkeep.

**KDADS Note:** Kansas is looking to transition away from tier system, but want to grandfather people in, make sure they don't lose eligibility & allow for exceptional funding.

Tier creep is a concern, there should be an even distribution between tiers, currently weighted towards tiers 1-3.

- Is the goal of the flat rate to be able to provide more people with services and spread the services out more evenly?
  - Jason & Theresa will look in to whether this is a reason, a lot of states are moving to flat rate.

#### Other Thoughts:

- Parent experience: MCO was offering exceptional funding for her child and providers still wouldn't serve them.
- Provider capacity is another issue to consider.
- Recommend reviewing notes from original MFEI workgroup.
- It's important to remember that the MFEI is a functional assessment, it doesn't determine services. MFEI just determines do they need waiver services or not.
- THE MFEI Workgroup met for a significant period of time, is this duplicating that work? Can we have a primer from that group re: what was done?
  - Response: Seth has reached out to Brutus and Carrie Wendell Hummel to get history.
- Did the MFEI group cover rate structure?
  - Response from someone on the group: No, but the history is helpful for context.
- Can we get final report from MFEI group?
  - Nan can ask her for report.
- System in place now is a holding place for MFEI – MCO has to finish assessment.
- Once this is implemented, need strategic meetings with providers, people served, families. Never too early to start the conversation.

## Wrap Up

#### Things to do prior to the next meeting:

- Theresa & Jason will follow up on how states were chosen for review.
- Theresa & Jason will look into the question: When there's a reference to tier or level of disability. Are we to assume that's done with the same functional assessment tool that they use for eligibility?
- Carri will add detail to the rate/funding report around assessments used, who does assessment, extraordinary funding process, how Ohio calculates cost of doing business
- Jason & Theresa will look into the question: Is the goal of the flat rate to be able to provide more people with services and spread the services out more evenly?
- Nan will try to get a copy of the final report from the MFEI Workgroup.

Next meeting:

- Carri will send a Doodle Poll to help find a date for the next meeting.
- Agenda will include responses to questions asked today. State team will work on getting a primer of the MFEI for the group.

# Functional Assessment Workgroup Meeting #2

Time: 1:30 p.m. – 3:30 p.m.

Date: 7/26/23

## Meeting Attendance

Organization	Representative
KDADS	Seth Kilber
KDADS	Jason Sheets
KDADS	Theresa Singh
WSU	Carri McMahon
WSU	Lisa Jones
Heartstrings	Rosanne Thiry
Johnson County CDDO	Nathan Haverkamp
N/A	Teresa Beaudry
N/A	Cassandra Sines
SSDI	Steve Sandoval
Johnson County CDDO	Jade Graham
Case Management Services, Inc.	Sarah Otto
Sunflower	Nanette Perrin

## Welcome/Introductions

### KDADS Updates

**MFEI history overview:** HCBS corrective action plan w/CMS, final settings rule corrective action plan, special committee on ID waiver – KDADS & the state to find a way to transition away from the basis, but make sure we do it correctly taking in many considerations. There is an F-map initiative that will be studying ID rates – in the early stages of developing that RFP. Plan is for a consulting group to come in and look at rates – directly ties into unbundling efforts through residential and day services. This group helps lay the groundwork down for what the state is trying to do as they bring in external partners and try to bring in more stakeholders.

Moderator: The scope of this group is not to solve every problem. We have talked about narrowing the focus of this group to exceptional funding and qualifying for exceptional needs and starting to identify potential barriers and problems. Is this in line with what KDADS is thinking for this group to focus on when looking at this very big topic?

KDADS agrees - a good place to start to focus this group on exceptional funding or qualifying for/having exceptional needs. Identify potential barriers. There is an assumption is the likelihood of what will happen, but who do we make this happen? What are the primary challenges? Identify different buckets since this topic is so large.

Comment: MFEI – functional eligibility assessment. KU was very clear that the level of care can only be used if the MCOs do the second half of the assessment. There is a data collection system/process that has not been developed or discussed.

Chat Comment: Do any parents have concerns about MCOs conducting "part" of the eligibility assessment?

Chat Comment: As a parent, I have mixed feelings about the MCO's conducting the assessment. Who at the MCO's would be doing the assessments? In the past, we have had trouble working with my daughter's MCO case manager knowing what services were available. Myself and my daughter's staff had to educate the case manager as to what was available. We ended up switching MCO's and the Case Manager she has now who knows what my daughter needs and strengths are and has done a great job.

Response: It was clarified that the MCO doesn't do the eligibility assessment. The piece they complete is a separate care planning portion of the tool.

We do currently have an extraordinary funding policy, for individualized rate and for super tiers, which is not appropriate anymore.

Comment: Need to call it something other than MFEI – the eligibility assessment is not being conducted by the managed care – the level of care is completed and that is what determines that they are eligible for the wave. The rest is a care planning portion.

KDADS Response: Currently under a licensing agreement with InterRAI – does require the state to utilize the full care planning. MFEI is based on the functional eligibility component right now. They should be using the full NRI – on their radar to be looked at. CMS did like some of what they saw of the use of the NRI – that it met some of the core components of the person-centered service plan.

For this group, KDADS is looking at a cost neutral approach – potentially grandfathering in at certain rates, transition phases – what do we explore since this is going live July 2024. How do we get from point A to point B?

Chat Comment: make sure to look at employment issues.

Response: There are questions on the care planning portion of the assessment.

Comment: Concerns from providers and parents included on potential changes in functional eligibility. What the plan of care will look like. Have some sort of moratorium of 3 years until it can be said it's been successfully implemented state-wide? Other state examples that utilize the NRI? Issues of providers not wanting to do the paperwork.

Chat response: But the BASIS did have folks not quality from one year to the next - would this not be different?

Chat comment: Thanks XX, I agree. I guess I was worried about this assessment excluding someone who has been receiving supports long-term.

Comment: Computer set up? MCOS will be ready for transition? AI replace? MFEI plus care planning would replace the basis? MCOS would have to ask the person served again – not a beneficial way to do it. How to get a system in order for the information to come over and just be part of the planning process.

Chat comment: For the love of all that is good in this world, make the systems TALK TO EACHOTHER (computer systems, not just people).

Chat Comment: My understanding is the MFEI is the Functional Eligibility screening of the InterRAI or kind of a Subtest in the overall? Would that be accurate?

Response: Yes XX- it is a portion of the InterRAI that was pulled out for the functional eligibility portion.

Primarily being able to demonstrate to CMS that we as a state are making a good-faith effort and making progress, but obviously doing it carefully. Not sure on other states – but NRI was chosen over other assessment tools because it did provide the ability to standardize the process across waivers. Also (potential goal of this group) finding ways to get providers the exceptional funding. Another iron in the fire – getting systems talking correctly to each other. How to do that – weaves into unbundling work groups because of having multiple residential services, multiple day services – aligned with different support needs that would hopefully inform the rates for those types of services. A lot of mapping to do.

InterRAI is the whole big picture, functional eligibility is a portion of that. MCOs each utilize their own care planning tool. InterRAI is designed to bring it all under one umbrella – hopefully allowing data integrity to go up, also.

Comment: Making sure persons served have the right person evaluating for needs/using the assessment so they get the care they need.

Comment: This is a very big tool. Is there room for changing it if it is only going to be used for functional eligibility? Maybe we should look at what we are working with before we get into the exceptionalities.

Response: Licensing agreement allows for up to around 5% modification.

KDADS: (Background of MFEI) A universal standardized assessment, critical for streamlining access to care for people seeking services. It seeks to promote choice (Goes along with the program CLTC – Charting the Life Course). Reduce admin. Burdens by decreasing the need for staff to perform multiple assessments. Having adequate funding is important and also promote equity. Capture standardized data that will help policy makers analyze program effectiveness. Stopped short of funding – wanting to give priority to that. Not necessarily conclusions or decisions from the group but brainstorm next steps and what it will look like. (IDD study will be done – cross pollinate, but not duplicate efforts). Contractor will be in around Sept. – be able to bring feedback from this group to that study. Additional committee looking at technical components (IT). Cost of doing business will be up to providers to determine for their area. But we can talk about funding.

Tiers are separate from eligibility. Trying to move away from tiers with extraordinary needs. Exceptional needs is a smaller portion, but making sure majority are also getting adequate services. Representation of groups will help with making of decisions.

Comment: We may not be making the decisions as this group (as we have been informed), but where can input have impact on the transition and timeline? Also, there is still a direct care worker shortage that will obviously not be changed by this.

### **Primary Focuses for the group:**

- Timeline / Steps for implementation
- Exceptional Needs - priorities and eligibility
- Administrative burden
- Protecting services/grandfathering

Comment: Can assessment be shared with this workgroup?

Response: KDADS will ask about viewing it, as it is a licensed product.

## **Discussion**

### **Criteria for exceptional funding?**

- Parents having a hard time even getting to exceptional funding due to process and denials. Could not even get to point of working numbers because of staffing issues. There is a gap that needs a solution.
- Flat rate funding states generally have more services available.
- Historically – EF was only for day/residential. Provider submitted information about services being provided to the individual. Includes salary information. Money not spent used to have to be given back. Hesitancy is on sharing salaries, also. Have to apply every year.
  - Chat comment: oh can we please go back to re-evaluating EF everything 3 years (if the provider stays the same)?
  -
- Is there a way to skip primary ins denials? (A CMS requirement) Is there a way to streamline this process to keep it from slowing down the process?

### **What is working well?**

- Independent TCM is working for assessment and finding services.
- 30 turn around for funding is appropriate
- providing supports to qualify
- looking comprehensively at plan
- currently a way to qualify for high medical need or high behavioral need.

### **What should make a personal eligible for EF?**

ADL's on more intense level (lifting supports, home modifications, transportation needs, etc.)

### **How to qualify for these?:**

- Motorized equipment needs (for transportation, showers, in and out of bed, etc.)
- Modified food consistencies
- TA supports
- 1:1 care more than 50% of the day

### **Current Eligibility criteria – Are these requirements meeting the needs?**

- Complications come with tier changes. Also, direct care shortages are a major issue with this.
- Co-occurring mental health needs can create issues in it.
- 6 levels, rating scale for eligibility for EF. Process for ADL qualification will need to look similar for med/behavior. for what makes a person eligible.

### **What are other ways to have the process for EF rate/funding look?**

- Personal care services process – can we use that tool?
- This tool might be more work than it is now? But there are tools available. To be able to go through hour by hour for what the supports would look like that would qualify for ADL EF. MCOs currently do the PCS assessment via interview. Have this be the proposal for ADLs.
- transitional period without having to apply for approval if moving from nursing home type facility to home. (Money follows the person will have some approval for EF built in and it starts in 2024.)
- Chat Suggestion: Standardized accommodations of checklist that we could breakdown by environments, staffing, outside community supports utilized/accessed/tried, antecedent interventions, and then a paragraph explaining the "individualized" nature of the services.

### **Wrap Up**

Next Meeting: Transition process, timeline, grandfathering or other protections.

# Functional Assessment Workgroup Meeting #3

Time: 1:00 p.m. – 3:00 p.m.

Date: 8/11/23

## Meeting Attendance

Organization	Representative
KDADS	Jason Sheets
KDADS	Theresa Singh
WSU	Carri McMahon
WSU	Lisa Jones
Provider	Rosanne Thiry
CDDO	Nathan Haverkamp
N/A	Cassandra Sines
CDDO	Jade Graham
Provider	Sarah Otto
Advocate	Matt Flecher
Family member	Connie Zienkewics
CDDO	Steve Sandoval
MCO	Nan Perrin

## Welcome/Introductions

### KDADS Updates

Transition schedule – wanting it to be fair and reasonable. Funding currently serving tier 1 on BASIS. Once updated, KDADS will email it out to group. For accurate schedule.

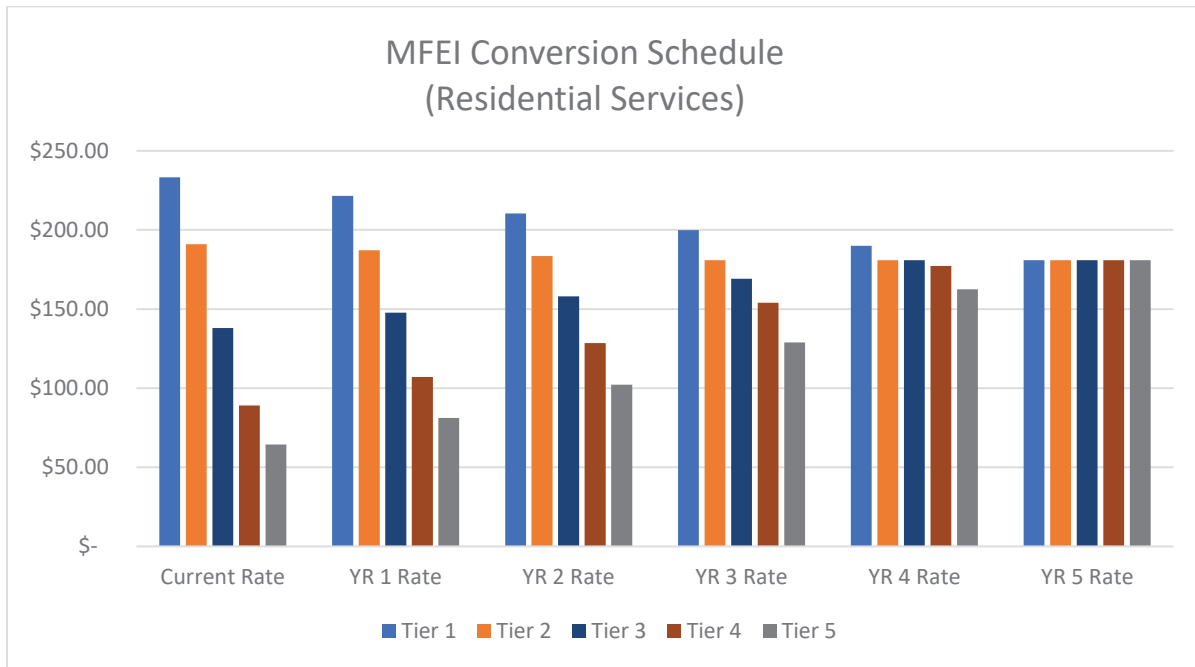
(KDADS emailed out most current MFEI conversion from BASIS)

Establish a more equitable distribution of funds. Promotes independence.

(Appendix A: Number of Service)

Number of Service Recipients per Tier (2023)		
Tier	2012	2023
Tier 1	20%	35%
Tier 2	20%	29%
Tier 3	20%	22%
Tier 4	20%	7%
Tier 5	20%	4%

(Appendix B conversion schedule projections)



Appendix B: Proposed MFEI Conversion Schedule for Residential Services (Continued)

Avg Rate	Avg # Recipients	Standardized Rate
\$192,870.73	1,066	\$180.86

	Regular Tier 1	Regular Tier 2	Regular Tier 3	Regular Tier 4	Regular Tier 5
Current Year	1915	1588	1177	401	251
# Recipients	1915	1588	1177	401	251
Current Individual Rate per Tier	\$ 233.20	\$ 191.01	\$ 138.08	\$ 89.17	\$ 64.44
Current Cumulative Rate per Tier	\$ 446,578.00	\$ 303,323.88	\$ 162,520.16	\$ 35,757.17	\$ 16,174.44
YR1 Individual Rate per Tier	\$ 221.54	\$ 187.19	\$ 147.75	\$ 107.00	\$ 81.19
Yr 1 Cumulative Rate per Tier	\$ 424,249.10	\$ 297,257.40	\$ 173,896.57	\$ 42,908.60	\$ 20,379.79
YR 1 Adjustment from Current Year	-5.000%	-2.000%	7.000%	20.000%	26.000%
YR 2 Individual Rate per Tier	\$ 210.46	\$ 183.45	\$ 158.09	\$ 128.40	\$ 102.30
YR 2 Cumulative Rate per Tier	\$ 403,036.65	\$ 291,312.25	\$ 186,069.33	\$ 51,490.32	\$ 25,678.54
Adjustment from YR 1	-5.000%	-2.000%	7.000%	20.000%	26.000%
YR 3 Individual Rate per Tier	\$ 199.94	\$ 180.86	\$ 169.15	\$ 154.09	\$ 128.90
YR 3 Cumulative Rate per Tier	\$ 382,884.81	\$ 287,204.75	\$ 199,094.18	\$ 61,788.39	\$ 32,354.96
Adjustment from YR 2	-5.000%	-1.410%	7.000%	20.000%	26.000%
YR 4 Individual Rate per Tier	\$ 189.94	\$ 180.86	\$ 180.86	\$ 177.30	\$ 162.42
YR 4 Cumulative rate per Tier	\$ 363,740.57	\$ 287,204.75	\$ 212,871.50	\$ 71,096.81	\$ 40,767.25
Adjustment from YR 3	-5.000%	0.000%	6.920%	15.065%	26.000%
YR 5 Individual rate per Tier	\$ 180.86	\$ 180.86	\$ 180.86	\$ 180.86	\$ 180.86
YR 5 Cumulative Rate per Tier	\$ 346,353.77	\$ 287,204.75	\$ 212,871.50	\$ 72,525.86	\$ 45,396.37
Adjustment from YR 4	-4.780%	0.000%	0.000%	2.010%	11.355%

Question regarding tiers/funding distro: Is that across all services with the tiers? Yes (tables above) Day & res is all that is reflected in chart, but would still be for all services. (Regarding Appendix B) Is that also for Appendix A? (KDADS will check to make sure Appendix A is also across all services, as it came from their CFO.) It would be interesting to see the same percentages just for those who get residential or day, because those are the only 2 that are “tier bound.”

Question from group: Tier 1 requires more services than tier 5 – 1 & 2 are overwhelmed, 5 may just decide to go without. How will KDADS make sure 3,4,5 apply for services and even it out? Assignment by dollars – how will that work?

KDADS: we want to be sure to address that. Wanting to make sure people are getting the level of care they need and no one falling thru the cracks. Determining parameters.

Question/comment: Ad board meeting (SG CO) 850 p/hr – how is this helping to bring staff wages up?

KDADS: there are other focus groups that are addressing that issue

KDADS: **What schedule do we think this should roll out in?** (Appendix B table)

Question/comment: anything short of 3 years would be too close. It would take almost a year to get it into their systems (MCO and CDDO) for system build up and training. Correct tool, being used the correct way.

KDADS: there is a group looking at the technical aspect.

Regarding 3year: what would it look like? Would tiers transition by year?

KDADS: Adjusting 1 year at a time. (appendix b)

Question/comment: A mentioned flaw: there should have been “resetting” over the years. Do we need to do that first, or take current spread and go with it?

KDADS: anyone have thoughts? Yearly? Bi-yearly?

Comments: MFEI clearly matches eligible/not eligible. Which is what it needs to do being flat-rate. Not needing to change algorithm of BASIS. Every 5?

KDADS: How do we calibrate that? For example, Tier 5 still needs a large amount of assistance to be successful.

Comment in chat: I think a lot of our Tier 5's require supports in executive functioning and skill deficits that are not current measured well by the BASIS.

## Thoughts on laid out approach of 5 years (appendix b)?

-Realistically to do this and keep doing tiers -BASIS and MFEI – double assessed. Longer you take in transition – they will have to get both assessments.

-Five-year would be easier for budgeting purposes. Stick to one year b/c of yearly budgets with providers. Three years might be a nice middle ground b/c 5 years seems like a long time to keep doing tiers.

Is the flat rate equitable for tier 1's? (Based on # of ind., current rate, ) KDADS will get updated model out.

Is tier 1 funding even sufficient right now? How was the equitable rate determined?

### Extraordinary funding:

Chat comment: nowhere near having buy-in from providers on this. There are a lot of concerns this is going to leave persons-served in a worse scenario than currently. And create opportunities for “cherry-picking.” Bring in providers in a meaningful way – beyond focus groups. (Keep in mind for barriers)

KDADS: Working on policy that couples with it: looking at uniform access of services for how decision are made to address “cherry-picking” concern.

Question/concern: providers building to accommodate needs (of all levels): if they have made that investment, they need to be able to recoup that keeps people safe and cared for well. Making sure to keep this in mind – not to alienate anyone.

Question/concern: Kids that are harder to place, cost more money to place – families are tired. We need to make it easier on families to get the help they need. There is a gap in the system.

Question/comment: Number of each tier who are entering the system in crisis? (ie – parent passing away, etc). The system has to absorb that, but how will that happen if it cannot cover the cost of care for that person at a flat rate?

Does InterRAI need to be up and running before this transition starts?

KDADS: Would need to have it in place as much as possible. Training will be on-going. We don't want to start anything without having proper systems in place to make it successful.

Question/comment: “Grandfathering” – what could this look like? Criteria? (question to KDADS)

KDADS: we can find more clarification on as we dig through documents. How eligibility is determined.

Chat question: Community support waiver to beta support test waiver for MFEI?

KDADS: timeline will not workout. CS waiver will take a while to bring to fruition. Not realistic for timeline.

### **Group thoughts on “grandfathering” who comes to mind on who could/should?**

- MFEI and not BASIS, lock in tiers. (support from others in group to lock-in tier while transitioning to MFEI)

- Would CMS even allow grandfathering?

KDADS: will talk to leadership about allowance of grandfathering from CMS.

Comment: long standing vs. new – does change go through CDDOs first and then they can serve as leaders for affiliates? By county, by agencies? Most support first then are willing to lead others. Withstand change and identify barriers to affiliates to help the people they serve. Introducing incrementally.

### **Thoughts on this (above)? Having a pilot group and opportunity for adjustments.**

- maybe residential providers that have been established longer years vs. new providers

- Providers (in their experience) are generally willing to step-up, there might be buy-in.

- CDDO areas did volunteer for a pilot on the MFEI

- might only get providers who have tier 4/5 if you are going to pay at a higher rate – so you may not get the ones who will use it for tier 1s (more work, no more pay will not volunteer, more work, more pay, not same experience will volunteer).

(There is a lot of data from the pilot from CDDOs who did MFEI. DPOK was one of them)

### **Barriers (KDADS is likely to see when making this change)**

- Could create a greater need in certain areas if providers close

- If supporting someone is not financially feasible, not having openings that fit the person being served.

- provider cherry-picking of who they will provide services for

- buy-in from providers

- provider capacity to serve high-need individuals

-A potential increase in complaints regarding length of assessment if there is overlap of the two assessments

-This is a piece of feedback I recently received regarding barriers... "The state is not looking at the big picture when making assumptions about tiers and funding. Great caution should be exercised when looking at a single-rate proposal. Our aging population and complex needs individuals who bypass the waiting list are changing the tier picture to a more expensive one when there is little activity on the waiting list." (Support from group on this)

-The MFEI was tailored to try to be more positive - but still get the information necessary - but still

-providers have made changes to serve higher needs but may not recoup funding for doing-so.

-Lots of information gathered on those members with co-occurring mental health needs and the inability to provide support to them - the crisis may grow instead of decrease

-Unbundling that is another group might help with some of these - depending on the recommendations (these other focus groups are working on defining additional day and residential services)

## **Wrap Up**

Next (final) meeting: Determining biggest barriers for transition & possible solutions.

# Functional Assessment Workgroup Meeting 4

Time: 2:00 p.m. – 4:00 p.m.

Date: 9/28/23

## Meeting Attendance

Organization	Name
SDSI	Steve Sandoval
Johnson County CDDO	Jade Graham
Life Centers of Kansas	Janna Dworkis
Case Management Services, Inc.	Sarah Otto
Heartstrings Community Foundation	Rosanne Thiry
University of Kansas	Claudia Dozier
InterHab	Matt Fletcher
	Dynel Wood
Life Centers	Jessica Dalton
WSU	Carri McMahan
WSU	Lisa Jones
KDADS	Theresa Singh
KDADS	Jason Sheets

## Welcome/Introductions

### KDADS Updates:

We have a detailed list of different levels of care document available, if desired. Showing potential different ways that would determine if someone needs a higher level of care (previous meetings we discussed what would trigger exceptional funding).

## Workgroup Discussion

### Barriers/Concerns:

-Providers spending money out of their own pocket for repairs, maintenance, etc. New flat rate will not cover expenses or be sustainable for providers. Some will lose \$500,000 a year. Providers are buying housing on their own to provide housing for individuals on waiver to live in, which if the provider falls out, the person will lose their housing. Providers will close doors in less than 5 years – a guarantee.

-Persons served will be losing the most based on flat rate. Individuals with high support needs will obviously have more needs (costs) than someone who has not at the same level. Doing a huge disservice to those on the waiver. The rate should be person centered, not a flat rate. Very concerning, need to have more providers on calls that can weigh-in.

-Flat rate will also impede service provision for behavioral, as well. HCBS/Final Rule – it will be impossible to do for those who have additional support needs to follow FR.

KDADS – typing up RFP to bring in a consultant who has experience deeply involved with this to look at the concerns.

-Does the MFEI automatically require flat rate?

KDADS: nothing is set in stone right now. The MFEI is what we are using, but the other pieces are not confirmed.

-MFEI tool does NOT require a flat rate – that is a decision that is being made unilaterally by KDADS. Previous workgroup met to decide of models – which did include experts from community. Seems like the workgroup that met for a number of years, that the outcomes from that group have been set aside in favor of new process. Consultant in place of community expertise – should have strong community collaboration. At a loss as someone who was part of that workgroup.

-What is the process with bringing in a consultant? How will community providers be included, updated, etc? It seems like providers don't know this is going on. There is a 10 year waiting list in KS. Already not enough providers.

-What is the consultant's expertise and experience?

-(Chat comment regarding consultant coming in) They have to be deeply familiar with the history of this project and understand the complexities and risks as well as opportunity to reduce CMS waste, fraud and abuse.

-(Chat comment regarding going to flat rate) and our population is aging, which will produce longer support needs and greater support needs for end of life care.

-(Chat question) Do we know how unbundling services/funding will look and how it interacts with a new evaluation method?

KDADS: There is a workgroup focusing on unbundling. On the RFP for the consultant – KDADS will report back that the message is clear that stakeholder/provider input is crucial. This cannot happen in a vacuum. We have to make sure it is implementable and not going to result in lots of closures.

-Concern expressed for what is/is not billable. Getting conflicting answers or no response back when asking for clarification. (i.e. – there are providers who are billing for residential every single day whether the person is present or not.)

-Should there be a Q&A workgroup?

-MFEI is fine – we do need to address the roll-out part so providers/parents are not having to do the BASIS and MFEI. But until flat rate/rate is determined – there is nothing to be decided around it. We can't make recommendations on it without knowing what is going to happen. And we don't want our names associated with an assessment that is going to potentially jeopardize the operations of all providers. As far as the MFEI and what the rollout looks like, we can talk about that and the BASIS, but we aren't going to move forward beyond that on behalf of everyone else.

-Do we start with Tier 1 (low hanging fruit) or Tier 5 because it will take the most?

-Comment regarding above question: Start with Tier 1 to get an idea of how it will go. Pilot group would limit individuals on who they could get services from.

-Is KanCare oversight aware of this? (Yes) Would be interested on what they would have to say about it.

-Not wanting decisions to be made behind closed doors without input from providers.

-Funding model needs to be figured out before productive conversations can be had to move forward.

KDADS (regarding many of the above concerns) - New table with more accurate figures have not been determined – figure given was just a sample. There is still a lot of work to be done. This is not something that is rolling out in the next few months. There will be ongoing discussion.

(Group determines not to move forward with recommendations around rates and the flat rate models until more accurate figures are available.)

## **MFEI/Assessment**

-How MFEI translates from BASIS? If we don't know this, it makes it hard to move forward with knowing barriers.

-KDADS – still working on rebuilding team.

-Assessment Transition by tier – start with all tier 1, then year 5.

(Chat comment) A lot of work done in prior years seems to have been lost. That is unfortunate.

(Chat comment) very unfortunate. Adds to list of barriers.

-There was testing done (years ago) to see how MFEI would compare to BASIS tier system. Wanting to make sure there wasn't a big drop off from people that were currently being served.

-(Chat comment) we know the comparison was done. Does anyone have the notes or information from when it was done?

Yes – KDADS can send it back out.

-(Chat comment) Use of MFEI as determining different funding? (Report overview says that, as well) (MFEI final report was shared in chat).

## **Small Group Discussion: Actionable ways KDADS can minimize barriers**

### **MFEI/Assessment**

Group 1 – Agreement on MFEI tiers needing to align. Seems like a whole lot of work, time and increased expense to administer, just to determine eligibility. That could also impact CDDOs – doing the assessment, going to multi-year approval means decreased revenue (because of not administering as frequently). But if it requires additional staff, then that is an expense increase. Liked graduated implementation.

Having a clear document outlining EF – for qualifying behavioral, medical, physical and any other category. Computer should be programmed to alert for potential qualification for each category. The state should be contacting the provider to do that. Stop putting it on the providers – a whole lump of money left sitting because it's a nightmare to access.

KS is a comprehensive waiver? Where is money going that is allocated, but not being used? (i.e. someone unable to use home supports due to high behavioral needs – where is the money going that was allocated for him for that when he doesn't use it?)

Group 2- Barrier identified as follow the work that was done earlier in order to move on. All the work notes and work that was done previously that are seemingly not available – those need to be identified/found and reviewed. How MFEI and BASIS align – can we get that information that was worked on?

Group 3 – Concerns for potential for “cherry-picking” in system sliding towards providing support for those with lower level needs. The system as it is underfunded and capacity is not robust – it could create those types of conditions. (WSU asked if there was any ideas discussed on how to prevent “cherry picking”?) Make sure we give ourselves time for good policy and system design and bring all the players to participate.

Barrier: results from pilot project that was ran a few years ago – seeing how the 2 evaluation methods compare to each other.

(Chat comment) If the answer to avoid cherry picking comes to providers being forced to serve anyone who comes their way it is in direct conflict with Final Rule.

### **Serving people with high needs:**

-Group 1 – Discussion of dual-diagnosis (mental health & IDD) – there is an extreme lack of services in this area, which is a bigger issue than how the assessment will impact these individuals. Standardizing a rate will lay the ground work for “cherry-picking” with providers (against these individuals). It would not aid services for those who would need double staffing or staff that need additional training in order to support that person.

-Group 2 – Same determination as other group - complex behavior and mental health issues would create the cherry-picking with a flat-rate. How do we avoid that?

-Group 3 – defining high needs & breaking it down – dual diagnosis, medically, behaviorally – challenges – has high rates of accusation (police, APS reporting), high rates of damage – all make it more costly to serve these individuals. Even with EF and a more simple process – we may not find staff with longevity in those homes. The costs outweigh the benefits. How does the safety of the family, staff in the home come into the cost of serving the person – potential need for carrying more liability or work comp insurance. There is a lot of oversight/“red tape” crushing the provider’s ability to do their job. Need to be able to say who can safely meet the needs of, not being required to take anyone and everyone just because they are open for referrals. Need to have staff that can sustain needs of high need individual. That limitation is being put on providers and they are having to close for a time to staff up for a high-needs individual.

### **Review & Input Possible Recommendations (from past meetings & today)**

**Flat rate funding:** Participants don’t feel comfortable making recommendations around flat rate funding – until there is feedback & input from more providers

#### **Extraordinary Funding:**

- Add ADL assistance to criteria category.
- The EF process works as it is – keep as is.
- Find ways to minimize provider burden.
- Make MFEI trigger EF, rather than provider application.

### **Implementation – Rate Change**

- Once this is implemented, need strategic meetings with providers, people served, families. Never too early to start the conversation
- 3 year implementation period-
- Work with more providers to get input on this change/plan. Use the expertise of the IDD community.

### **Implementation – Assessment Change**

- Once this is implemented, need strategic meetings with providers, people served, families. Never too early to start the conversation
- Recommend reviewing & utilizing the recommendations and work from the original MFEI workgroup.

### **Rate**

- Like consideration of cost of doing business. Kansas didn't make changes for a long time and needs a plan for upkeep.