

## MEMORANDUM

**To:** Dorothy Klein  
Director of Human Services  
Delaware County  
**From:** Ronald G. Henry  
**Date:** December 3, 2007  
**Subject:** MR Waiver Issues

You have asked me to review the MR/DD waivers received by several states from the Centers for Medicare and Medicaid Services (CMS), with a view to evaluating the significance of issues raised by CMS and/or state agencies with respect to the role played by counties in the delivery of services provided under the provisions of such waivers. Specifically, your concerns arise from plans proposed by the Pennsylvania Department of Public Welfare (DPW) to make substantial changes to long-established processes under the Commonwealth's mental retardation waivers, which in your view will significantly weaken the authority of counties to oversee providers, coordinate services and otherwise administer their mental retardation program. The immediate concern relates to the recently renewed Home and Community Based Services §1915(c) waiver, but it is expected that as other waivers come up for review similar actions will be taken.

States have chosen to administer their MR/DD programs in different ways, some electing to hold all authority and responsibility at the state level, others delegating certain powers to local government units (or entities created under the authority of local governments). Pennsylvania has a history of empowering county MR programs for both state-funded and waiver-funded services. Notwithstanding that history DPW has advanced changes which would centralize many aspects of the Pennsylvania system, ostensibly under pressure from CMS to do so in order to make the waiver program more uniform and statewide in application. Delaware County and other counties have worked with DPW to deal with the impact of the proposed changes. They have objected to the fundamental shift in approach and have expressed serious concerns about DPW being able to implement its changes in accordance with the deadlines it has imposed.

In general, your concerns relate to county-level powers to select, contract with, set rates for, pay and discipline providers. You are also concerned about the mandate to use a standardized evaluation instrument. Particularly, you are of the view that the proposed restructuring of waiver services will both undermine the ability of counties to effectively represent the interests of the Commonwealth, CMS and consumers and place counties in the position of having huge responsibilities and little authority.

### State Programs

We identified several states as having MR/DD programs similar to Pennsylvania's in structure – systems which look to counties to bear a substantial portion of the responsibility for the administration of such programs generally, and with respect to waiver programs in particular. Among those states, we chose to make more detailed inquiry with respect to Minnesota, Michigan, Ohio, and Wisconsin, all of which administer MR/DD programs under CMS waivers. All of the states are somewhat similar to Pennsylvania in their rather distinct division among urban, suburban and rural demographics, in some degree mimicking the Commonwealth's size and diversity. In the case of Minnesota and Michigan, we spoke with people who had both statewide and county-level perspectives, while conversations concerning the other states were conducted with state-level officials only.

*If there is a general theme that runs across all four states, it is that none have imposed the full range of changes on counties that DPW has proposed in Pennsylvania, notwithstanding efforts by CMS in some cases to promote greater centralization. Whether those results were the product of less forceful pressure by CMS during the waiver renewal process or more effective advocacy by state and local officials is not clear.*

### *Minnesota*

I spoke with Alex Batolic, who is Minnesota's Director of Disability Services, HIV and AIDS, who referred us to Milt Conrath, the administrator of the Dakota County DD program. In general, Minnesota provides substantially more autonomy and authority to counties operating waiver programs (in this situation also a §1915(c) waiver) than does DPW under its proposal.

- The Minnesota system requires counties to create and maintain a provider network which assures adequate choice of qualified providers, but it does not require that counties retain all providers who seek to have a contract, thereby moderating the risk of creating a universe of weak entities.
- Although its system is generally county-based, Minnesota has chosen to centralize provider payments at the state level. While its system has payment constraints limited by the number and type of authorized services, it is not clear whether there is an effective means of ensuring that providers do not over bill. Unlike what DPW has proposed, however, the Minnesota system seems to lodge significant responsibility in counties to allow them to oversee the qualitative terms of the contract.
- The state does not constrain or regulate what counties pay providers in comparison with what is paid by other counties for the same services.
- Counties have flexibility to manage available funds and make mid-year changes to deal with fluctuations in population and utilization.

### **Michigan**

There were two calls concerning Michigan, one with Don Hoyle, the executive director of The Arc Michigan, and the other with Paul Ippel, director of "Network 180," which is the name taken by the Kent County (Grand Rapids) DD program, to whom Hoyle referred us.

Mental health and developmental disability services in Michigan are coordinated through local Community Mental Health Service Programs, which operate with a great deal of autonomy. The state financially supports the CMHSPs (controlled by counties), and they are the primary point of contact for DD consumers and families.

In the call with Ippel, he noted:

- The state's HCBS waiver was recently renewed, without major effort being made to change the county-state balance
- Counties receive capitated payments (combined with severe MH population), with some weighting for clinical characteristics of members.
- Counties get funds and pay invoices directly.
- There are no state uniformity mandates as to rates or terms of contracts, although the state is reportedly considering how to deal with disparities across providers, counties and areas.

- Counties have discretion in terms of provider qualifications and numbers, within Federal requirements for consumer choice.
- Counties have flexibility to manage available funds and make mid-year changes to deal with fluctuations in population and utilization.

## **Ohio**

MR/DD services are coordinated by the state's Department of Mental Retardation & Developmental Disabilities, operating through 88 county MRDD Boards which serve more than 75,000 children and adults. I spoke with Michael Schroeder, Manager of Community Services Development and Special Projects for the Department of Mental Health, who serves as the liaison with the Department of Mental Retardation & Developmental Disabilities.

In a call with Schroeder, he said:

- Each county operates its system through a board appointed by the county, within Ohio's tradition of strong county-level home rule.
- Contracting with providers is done on a county level, and while Ohio is an any willing provider state, there are standards of suitability which counties use.
- While the state has the authority to oversee provisions in county contracts with providers, there is no state-mandated contract template. Counties have authority to enforce the terms of provider agreements, backed up by a state registry of adverse events (to address qualitative and safety concerns).
- Rates are also determined on the local level, although the state exercises some indirect influence by virtue of its approval of individual consumer budgets through development of an individual Developmental Disability Profile, which circumscribes what counties can do within the amount of available funds and still meet their obligations. Counties provide the match to federal FFP through a mix of state-provided funds and county revenues. There is no direct state match of Federal Medicaid dollars.
- The state is considering how they should act to "flatten" the differences among provider rates across the state, although he said that the state realizes that different market areas would have different profiles.

## **Wisconsin**

The state administers its program through the Bureau of Developmental Disabilities of the Department of Health & Family Services. Contact was made there with Ken Golden, Division of Long Term Care, Bureau of Long Term Support.

Golden said that CMS has been very aggressive in trying to force the state to erase intra-county differences, he believes with the CMS goal is to eventually either eliminate their role entirely or to make them solely arms of a very homogeneous state program. That said, he noted that Wisconsin counties continue to have a broad range of authority allowed to them in the administration of the waiver programs. Specifically:

- The state does not mandate provider rates, although the counties provide about half of the state's Medicaid match for waiver consumers.

- There is no state-required contract form, and counties perform oversight of provider conduct.
- Counties get an advance payment from the state – in anticipation of federal funding - to allow them to pay providers promptly, with later-arriving federal funds both reimbursing the state and supporting the counties going forward into the year. Golden says that CMS does not like the system because it separates financial control from state-level responsibility.
- Within state-imposed qualitative (care-related) guidelines (security, background checks and training), counties have the authority to deal with qualitative issues and provider retention/oversight/discipline.
- The state has concerns about preservation of choice, but also shares concern that smaller providers have to be supported and/or have to be credible. In structure, Wisconsin is legally an any willing provider state, but counties continue to be able to manage the number of providers in their systems.
- The state is moving towards a managed care paradigm, which seems to have taken some of the pressure off counties as the use of MCOs will drive the system towards a more homogeneous approach.