

Behavioral Health Division

Meeting Minutes

Meeting	BHD Waiver Redesign Stakeholder Steering Committee <i>revised</i>	Date	April 5, 2013	
Facilitator	Joe Simpson, BHD DD Section Administrator	Time	start 10a	Stop noon
Location	WDH Century Link Bldg Basement Conference and Training Room, LL20 Cheyenne, Wyoming Or by phone 1-877-278-8686 Code 058448	Scribe	Shaun Wilhelm, BHD	
Attendees	Charlie Briggs, Shannon Buller, Heather Dodson, Kathy Escobedo, Garry Freel, Shawn Griffin, Buck Gwyn, Glenda Haley, Pat Kolarik, Kim Latta, Chris Newman, Brenda Oswald, Colleen Pillon, Shirley Pratt, Heather Ripley, Wanda Rogers, Sandy Root-Elledge, Rory Schiffbauer, Joe Simpson, Emily Smith, Jesse Springer, Jamie Staunton, Beverly Swistowicz, Linda Treese, Aaron Wales, Shaun Wilhelm, Marilyn Skogen, Ellen Merchant, Ragen Lathem, Christine Bates, Matt Hager			
Meeting Purpose	To provide feedback to Chris Newman, BHD Senior Administrator, and the Waiver Redesign Core Team regarding the redesign and implementation of the new Supports Waiver and Comprehensive Waiver.			

Agenda & Summary Minutes

No.	Topic – Person Presenting	Amount of Time	Summary Highlights
1.	Welcome –Joe	5 min	Introductions were done.
2.	Abbreviated Forum presentation-Joe	30 minutes	<p>Handout Before Joe presented the abbreviated forum presentation he asked for input from those that had attended the Casper forum the night before.</p> <p>Joe went through abbreviated forum presentation. He asked for input from the presentation for the 2 questions that are in the presentation. The two questions are from the Wavier Redesign Survey. The first question was about how to fund an additional 500 people from the waitlist with current funds and the second was to list the top 5 most valuable services on the waiver. The stakeholders filled out the survey and handed their responses in at the end of the meeting.</p>
3.	Conflict Free Case mgmt. discussion	15 Minutes	Will be tabled until next meeting.
4.	Survey Completion and Discussion – Joe	15 Minutes	<p>Joe asked each of the respondents for each of the 2 questions from the presentation: <i>* how to fund an additional 500 individuals:</i></p> <ul style="list-style-type: none"> • Use more natural supports • Eliminate the provider ratios • Providers able to negotiate rates • Increase the use of other governmental agencies <p>For the top 5 most valuable those responses will be tabulated with the rest of the surveys. Case management was mentioned as an important service for participants to have to coordinate services.</p>
5.	Vision brainstorming for Waiver redesign 10 & 15 years out - Joe	20 Minutes	<p>Joe asked for a word or phrase that would help define the stakeholders' vision of the waiver 10 to 15 years in the future. Here are the phrases or words that were mentioned:</p> <ul style="list-style-type: none"> • Making own decisions and living by oneself • Focus on people not paper

		<ul style="list-style-type: none">• Relationship Based• Potential• Flexibility• Have stable services• Outcomes-based• Provide services that are appropriate• Formalize supports• No wait list• Meaningful community integration• Community and Safety net• Support Families, family needs met• Flexibility of services• Truly person centered• Taking risks• Get out and go• Independence• Meaningful & appropriate community integration• Family Supported• Happiness for all• Flexibility for change• Optimum quality services
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6.	Eligibility Team Discussion – Beverly	15 Minute	<p>Handout There were 12 options presented on the eligibility handout for the committee to consider. Here is a summary of the responses for each of the 12 options:</p> <ol style="list-style-type: none"> 1. Closing case if no case manger is chosen in 45 days – There were no comments from the stakeholder committee. 2. Closing case if level of care is not completed in 30 days – There were no comments from the stakeholder committee. 3. Closing case if family does not determine financial eligibility in 45 days – There were no comments from the stakeholder committee. 4. Changing psychological eval requirement (remove every 5 years) – There was a question of if there is a change in medical status would a new evaluation need to be done? 5. Combining ABI and DD – CMS informed the BHD that currently ABI and DD populations need to remain separate until CMS changes their rules. 6. More stringent eligibility requirement such as cap of ICAP score of 70 – Also discussed was that there are 244 participants currently on the Adult DD waiver with an ICAP above 70. One of the options considered was having a cap of 70 ICAP score for eligibility for the waiver. Caution was advised because if a participant has an ICAP over 70 they might have a dual diagnosis and they would still need to be on the waiver. 7. Move from ICAP to SIS – It was explained the advantages of the SIS over the ICAP but it would be a while before BHD could use it as an assessment tool. The white paper done by WIND will be sent out to the committee for them to review.
			<ol style="list-style-type: none"> 8. Beginning DD waiver at 5 yrs old – It was mentioned that parents might need the respite and the medical before the age of 5 and that caution should be taken when considering raising the age eligibility to 5 yrs old. 9. Keeping institutional requirements – There were no comments from the stakeholder committee. 10. Keep LT-104 – There were no comments from the stakeholder committee. 11. No change in financial eligibility – There were no comments from the stakeholder committee. 12. Changing wording from mental retardation to intellectual disability – There were no comments from the stakeholder committee.
7.	Agenda planning for next meeting - Joe	10 Minute	Joe mentioned that if the committee wanted to have a topic covered in the next meeting to email Jamie.
8.	Plus/Delta - Joe	5 Minute	<p>Plus:</p> <ul style="list-style-type: none"> • Liked the power point. • Liked the pro/con format for committee members to see for each of the option on eligibility. • Liked the technology • Liked having the power point and the handouts in advance <p>Improvements:</p> <ul style="list-style-type: none"> • Try to get handouts to committee members sooner. • Phone participants couldn't always hear what was said.

Follow-up Action Plan

No.	Action Item(s)	Owner	Target Date
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1.	Next Meeting April 19 th from 10a to noon	Team	4-19-13
2.	Get powerpoint with notes out to team	Jamie	4-13 done
3.	Powerpoint or presentation on the website	Jamie/Sharla	4-13 almost!
4.	Gather average costs per person	Shaun	4-13
5.	Clarify with Medicaid if getting a new psych eval when there is a medical necessity is currently an option # of kids under 5 on wait list see info below	Bev	4-13 Done
6.	Dr. MacLean's paper on SIS/ICAP out to people	Jamie	4-13 Done
7.	Put new FAQs on website	Jamie	4-13 Done

From Bev:

- # of kids under 5 on wait list is 42
- 8 are 1 yr or younger
- 10 are 2 yrs

She can break down the rest if needed

On Mon, Apr 8, 2013 at 4:40 PM, beverly swistowicz <beverly.swistowicz@wyo.gov> wrote:

We are recommending that we discontinue the requirement for a psychological every 5 years to remain waiver eligible. But we know, there are times when a new psychological is warranted. When would Medicaid pay for a new psychological? For instance, if the participant has matured, if the participant is showing signs of dementia or other mental decline. Is there are rule of thumb and how would a team go about requesting a new psychological? Would there need to be a physician's order?

On Tue, Apr 9, 2013 at 8:50 AM, Lisa Brockman <lisa.brockman@wyo.gov> wrote:

A physician may refer to a psychologist but that isn't necessary for a psychological evaluation to be performed. Cognitive issues, speech issues/aphasia, signs of other medical issues such as stroke or TIA's, etc., may require an evaluation be a physician or psychologist to assess current status. Also, issues related to co-occurring mental health and or substance abuse disorders may require periodic assessments if there is reason to believe that client's condition requires testing to better inform the treatment plan. I would expect to see those types of diagnoses as primary in the situations described above.

Where we run into issues are psychological services (including testing) that are billed under the rehabilitative services option that have a primary diagnosis of 317 or 318. These diagnoses aren't considered to be amenable to rehab. However, one of the other co-occurring issues as mentioned above are. I have provided a V code for providers to use when testing for waiver eligibility to take the place of 317 or 318. That was part of the rehab. bulletin that went out after we all met about the hab vs. rehab issues. Does that make sense?

If someone had a diagnosis of MR or ABI but was showing signs of dementia, the psychological would be covered as long as the psychologist used the dementia code, not the MR code. The V code we gave them to use for a diagnosis when doing the screenings for MR or other related conditions is "assessment for developmental or mental health conditions" which works for the psychological evaluations when they are assessing for eligibility so they don't have to use the MR diagnosis codes but they don't have another condition, like the one you listed, that they are trying to determine.