



October 31, 2022

To: 2022 Special Committee on Intellectual and Developmental Disability Waiver Modernization

From: Iraida Orr, Principal Research Analyst

Re: Responses to Requests from September 28 and October 13 Meetings

The following information was requested by members of the Special Committee on Intellectual and Developmental Disability Waiver Modernization (Special Committee) at its meetings on September 28 and October 13, 2022.

The documents referenced below are posted on the [Special Committee's](#) page on the Legislature's website with the October 13, 2022, testimony and are included in the minutes for that meeting:

- Kansas Legislative Research Department (KLRD) staff provided copies of the Basic Assessment and Services Information System (BASIS) instrument. The Supports Intensity Scale (SIS) assessment is proprietary and not available. Links to assessment information were provided by Roundtable members Brenda Jackson and Jawanda Mast.
- Roundtable member Rocky Nichols (Executive Director, Disability Rights Center of Kansas) provided a list of common disability acronyms requested by the Special Committee.

September 28, 2022, Requests

The documents in response to September 28, 2022, requests referenced below are posted on the Special Committee's page on the Legislature's website with the November 1, 2022, testimony and will be included in the minutes for the meeting:

- A request to KLRD for the number of states that provide self-directed goods and services:
 - At least 22 states have 1 or more waiver that offers the service of "self-directed goods and services." These states are Alabama, California, Connecticut, Georgia, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Missouri, Montana, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, West Virginia, and Wisconsin.

- For more information on waivers in each state, please see the “[Home and Community Based Services Intellectual and Developmental Disability Waivers by State](#)” spreadsheet created by KLRD and included as testimony at the September 28 meeting.
- A request to KLRD for information on different forms of transportation provided across the states that are paid for on the I/DD waivers and how the transportation is funded.
 - A spreadsheet was provided by KLRD staff and included as testimony at the meeting on November 1, 2022.
- A request was made to state agencies that presented at the September 28, 2022, meeting inquiring about each state’s procedure for transitioning individuals with intellectual and developmental disabilities (I/DD) from a lower-benefit waiver to a higher-benefit waiver. The response from the Missouri Department of Mental Health, Division of Developmental Disabilities, was provided after the October 13, 2022, meeting and is as follows:
 - **Missouri:** Emily Luebbering (Federal Programs, Missouri Department of Mental Health) noted Missouri has two lower-level waivers, and individuals might move to a higher level waiver due to additional needs increasing the individual’s annual cost. The Partnership for Hope waiver has an annual cost limit of \$12,362 and if needs increase beyond that limit, the individual would typically move to the Community Support Waiver, which has an annual limit of \$40,000. Exceptions may be granted beyond the \$40,000, and if an individual is in crisis and needs residential services, they would move to the Comprehensive waiver. Below are further details on each waiver’s process. Further details are available at [Medicaid Home and Community Based Waivers_dmh.mo.gov](#).

– **Community Support Waiver**

- Individuals are assessed prior to entering this waiver and annually to identify their needs and estimate the cost of waiver services necessary to meet the needs. If the estimated cost of waiver services exceeds the limit initially or after entering the waiver, the individual is considered for participation in another Developmental Disability (DD) waiver that can meet their need and does not have a cap.
- In advance of enrollment in the waiver, the needs of the individual and how best to meet the needs are identified. From this assessment, a plan of care is developed that specifies the amount, frequency, and duration of all services that are needed to assure health and safety. All potential sources for meeting the needs will be explored such as private insurance, other federal programs, State Plan Medicaid, other state and local programs as well as non-paid support provided by family and friends. The plan/budget is sent through the Utilization Review Committee, which reviews the request and proposed costs. The committee makes a recommendation to approve, change or deny all or some services proposed in

the budget based on statewide Utilization Review (UR) Committee criteria (9 CSR 45-2.017). If the individual's needs cannot be met within the cost limit, the Comprehensive Waiver will be considered.

- If there is a change in the participant's condition or circumstances that results in increased needs and services to assure the participant's health and welfare, the case manager will propose a change to the plan. The changed plan will be subject to utilization review. The UR Committee may approve or deny the changes, or may recommend alternative solutions. If increased services are denied, the person will be advised in writing and will be provided information on appeal rights.
- If a proposed plan or proposed change to a plan will cause the annual cap to be exceeded but the services are deemed necessary to protect the person's health and safety and/or prevent the person from entering an institution, an exception can be requested. Exceptions may be approved by the Division of Developmental Disabilities (Division) Director, or a designee, for a one-time expense, during a crisis or a transition period, or other circumstances supported by a recommendation from the regional office's UR Committee.
- Individuals participating in the waiver will not lose eligibility for service due to an increased need for a covered service that causes the total need to exceed maximum amounts established by the State.
- Examples of action the planning team may take to assist the person in accessing additional services that are required for health and safety and to avoid institutionalization are: seeking additional natural supports; considering access to non-waiver State or county (local) funds; requesting approval for an exception from the Division Director or designee, to exceed a maximum limitation for a one-time expense, or during a crisis or transition period; and/or providing the person information regarding other Missouri waivers, such as the DD Comprehensive Waiver, and providing assistance with applying and transitioning as needed.
- If it is determined that the individual's health and welfare cannot be assured in the community by any or a combination of the above actions, the State may find it necessary to discharge the person from the waiver and may recommend institutional services.

Other Safeguards

- When there is a change in the participant's condition or circumstances, the needs of the individual are reevaluated. In some cases, an exception to the cap may be authorized,

or the individual may be referred to other services, which could include the DD Comprehensive Waiver.

- An individual is reevaluated as their needs change or the individual requires more significant supports. The change in needs and supports is updated in the person-centered plan, and the individual may transition to another waiver that offers the services needed.

– ***Partnership for Hope Waiver***

- If there is a change in the participant's condition or circumstances that result in increased needs and services to assure the participant's health and welfare, the case manager will propose a change to the plan.
- The changed plan will be subject to UR. The UR Committee may approve or deny the changes, or may recommend alternative solutions. If increased services are denied, the person will be advised in writing, and will be provided information on appeal rights.
- If a proposed plan or proposed change to a plan will cause the annual cap to be exceeded but the services are deemed necessary to protect the person's health and safety and/or prevent the person from entering an institution, an exception can be requested. Exceptions may be approved by the Division Director, or a designee, for a one-time expense, during a crisis or a transition period, or other circumstances supported by a recommendation from the regional office's UR Committee.
- Individuals participating in the waiver will not lose eligibility for service due to an increased need for a covered service that causes the total need to exceed maximum amounts established by the State.
- Examples of action the planning team may take to assist the person in accessing additional services that are required for health and safety and to avoid institutionalization are: seeking additional natural supports; considering access to non-waiver State or county (local) funds; requesting approval for an exception from the Division Director or designee, to exceed a maximum limitation for a one-time expense, or during a crisis or transition period; and/or providing the person information regarding other Missouri waivers such as the DD Comprehensive Waiver and providing assistance with applying and transitioning as needed.
- If it is determined that the individual's health and welfare cannot be assured in the community by any or a combination of the above actions, the State may find it necessary to discharge the person from the waiver and may recommend institutional services.

- If an increase in services is approved and there is no alternative means of meeting the needs, an exception may be granted. The County Board or other not-for-profit entity director will request the exception. Exceptions must be approved by the Division Director or designee. An exception may be granted to exceed the annual individual cost cap for a one-time expense or during a crisis or transition period in an amount not to exceed \$10,000. An exception may be granted to exceed the individual cost cap for an ongoing excess amount of up to \$3,000 annually.
- There are reserved slots in the Community Support Waiver for crisis and reserve slots in the Comprehensive Waiver for crisis and transition in the event residential supports are necessary.

Other Safeguards

- When there is a change in the participant's condition or circumstances, the needs of the individual are reevaluated. In some cases, an exception to the cap may be authorized, or the individual may be referred to other services, which could include the DD Community Support or Comprehensive Waivers.
 - An individual is reevaluated as their needs change or the individual requires more significant supports. The change in needs and supports is updated in the person-centered plan, and the individual may transition to another Waiver that offers the services needed.
- A request was made to state agencies that presented at the September 28, 2022, meeting inquiring about each state's method to tailor services to meet an individual's specific needs, whether services available to an individual but not needed could be provided to another individual or would remain unavailable, and how the states address this. The Missouri Department of Mental Health response, which was provided after the October 13, 2022, meeting is as follows:
 - **Missouri:** Ms. Luebbering noted:
 - Only waiver services identified as needed by the individual in the individual support plan are provided to the individual. There is no limit to number of waiver services that an individual may receive, but the service must be identified as a need in the individual's support plan and approved by the utilization review process.
 - The individual support plan is developed through a person-centered planning process. No later than 30 days from the date of acceptance into the waiver program, the interdisciplinary planning team develops a support plan with the individual. Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in relationships, things to do, places to be, rituals and routines, a description of immediate needs, especially those that are

important to the person's quality of life including health and safety and information about what supports and/or services are required to meet the person's needs.

- The plan is based on the support coordinator's functional assessment of the individual and all other assessments that are pertinent. The Division uses standard tools to determine level of functioning. Assessments specified in Chapter 2 of 9CSR-45 such as the Missouri Critical Adaptive Behaviors Inventory (MOCABI) and Vineland are the typical tests of adaptive behavior for all waiver participants. Other formal normative-based, standardized assessments of adaptive function may be used to supplement or replace the MOCABI and Vineland. In addition, educational, psychological and medical records, etc. may be used to assist in documenting the individual's diagnosis and level of functioning. Assessments include observations and information gathered from the members of the team.
- The functional assessment determines how the individual wants to live, the individual's routines, what works for the individual and what does not. It also assesses what the individual wants to learn and how the individual learns best. It measures how independently the individual functions and what interferes with what the individual wants, and it suggests ways the individual's needs and wants can be met.
- Upon being determined eligible for Division services, each individual and/or legal representative, or guardian receives information regarding available services and programs, including information about the waiver. After needs are identified through the planning process, the support coordinator reviews this information once more and with the individual and the interdisciplinary team. Specific services and supports are then identified to meet the participant's needs.
- The plan specifies all the services and supports that are needed and who is to provide them, to enable the individual to live the way the individual wants to live and learn what the individual wants to learn. Individual Support Plans (ISPs) address all supports and services an individual is to receive. This includes services provided through the waiver, other state plan services and natural supports. For each need that is expressed, the plan must describe what support or service is being provided to meet that need. Providers selected by the individual are responsible for providing services in accordance with the plan. The support coordinator is responsible for coordinating services provided by other agencies or individuals and monitoring the provision of services during routine monitoring visits.

October 13, 2022, Requests

- A request for KLRD to contact the Kansas Department for Aging and Disability Services (KDADS) to inquire if it would be possible to have one state department

to deal with all matters related to the I/DD population, and whether any Centers for Medicare and Medicaid Services (CMS) or other federal rules would prohibit creating one such department:

- KDADS noted many states do have separate I/DD agencies. CMS requires that there be a single state agency for Medicaid, which is the Kansas Department of Health and Environment (KDHE). However, a stand-alone I/DD-specific agency could work with KDHE, as KDADS currently does for the Home and Community Based Services (HCBS) Waivers.
- A request for information regarding the contract between KDADS and the Kansas University Center on Developmental Disabilities (KUCDD) for the I/DD Wait List Study:
 - KDADS provided a copy of the contract. This document was provided as testimony at the meeting on November 1, 2022.
- A targeted case management (TCM) rate of \$75 per hour was suggested to get to a level of sustainability. A request was made for what the \$75 per hour would pay for:
 - Matt Fletcher, Executive Director, InterHab, provided a description of TCM services from the Kansas Medical Assistance Program ([KMAP](#)) manual:
 - Targeted Case Management: Targeted case management services are defined as those services which will assist the beneficiary in gaining access to medical, social, educational, and other needed services. Targeted case management includes any or all of the following services:
 - Assessment of a beneficiary to determine service needs by: taking the beneficiary's history; identifying the beneficiary's needs and completing the related documentation; gathering information, if necessary, from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the beneficiary;
 - Development of a specific support/care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other service needs of the beneficiary; includes activities that ensure the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's legal representative) and others to develop such goals and identify a course of action to respond to the assessed needs of the beneficiary;
 - Referral and related activities: to help a beneficiary obtain needed services, including activities that help link the beneficiary with medical, social, educational providers, or other programs and services that are capable of providing needed services, such as referrals to providers for needed

services and scheduling appointments for the beneficiary;
and

- Monitoring and follow-up activities, including: activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the beneficiary's needs, which may be with the beneficiary, family members, providers, or other entities and conducted as frequently as necessary to determine whether:
 - Services are being furnished in accordance with the beneficiary's care plan;
 - The services in the care plan are adequate; and
 - There are changes in the needs or status of the beneficiary and, if so, making necessary adjustments in the care plan and service arrangements with the providers.
- A request regarding whether the mental health TCM code rate was also \$43/hour.
 - KDADS noted TCM is only provided for the I/DD and Serious Emotional Disturbance (SED) Waivers, and the rate for both of those is \$10.83 per 15 minutes. Outside of the HCBS waivers, TCM is also provided for Adult Mental Health, and that rate is also \$10.83 per 15 minutes.
- A request to KLRD for information regarding what other states do as best practices to meet the needs a navigator would address. Do other states look to regents institutions that have social work and counseling programs and partner with them to meet these needs in their service area?
 - KLRD provided a memorandum in response to this request. This memorandum was distributed at the meeting on November 1, 2022.
- A request was made to KDADS for the cost of the BASIS assessment, the amount the State spends for administration of BASIS, and the reason the State uses BASIS:
 - KDADS noted it pays community developmental disability organizations (CDDOs) \$150.00 for each assessment. BASIS training is done by CDDOs and comes out of their administrative budget. Information on licensing fees is pending.
- A request was made to KDADS for the cost to transition to the MFEI:
 - KDADS noted it needs to identify how funding will be determined while utilizing the MFEI. While the MFEI is an assessment tool to determine the level of care, there is not a way to tie tier funding to the assessment. KDADS IT staff would have to develop a system to pull the assessment information into the Kansas Assessment Management Information System (KAMIS). Other costs would include developing a new contract with the CDDOs, as well as training costs associated with the transition.

- A request was made to KDHE for additional information on how long it would take to switch to the SIS assessment, the steps involved, and the cost:
 - KDHE noted switching to the SIS assessment would involve, at a minimum, amending the current 1915(c) waiver. There is no guaranteed timeline for amending an HCBS waiver. After an amendment is submitted for approval, CMS has 90 days to approve, disapprove, or issue a request for additional information (RAI). If CMS issues an RAI, a new 90-day clock starts after the state responds to the RAI. If it appears that CMS' concerns will not be fully addressed during the second 90-day period, the state has the option of taking the waiver "off the clock" to avoid CMS having to issue a denial. This means it can take fewer than 90 days, or up to an indefinite period of time for a waiver amendment to be approved. There are states with waiver amendments that have been pending for years. Sarah Fertig, Medicaid Director, will provide additional information during the November 1, 2022, KDHE Update presentation.
 - KDADS noted the steps involved in switching to the SIS assessment include:
 - Amending the current 1915(c) waiver;
 - Obtaining a SIS license;
 - Working with stakeholders to identify any needed modifications;
 - Providing training on the new assessment; and
 - Making information technology (IT) changes.
 - KDADS also noted, in working with the Medicaid Functional Eligibility Instrument (MFEI), the process of modifying the tool, meeting with stakeholders, training community developmental disability organizations (CDDOs), and modification of the State IT system has provided an example that a change to the SIS would not be a quick process.
- A request was made to KDADS to provide an update on the comprehensive research done on the MFEI:
 - KDADS noted the following remains to be done in order to implement MFEI:
 - Update or replace the I/DD tier system;
 - The tier rate will be complicated if it is incorporated into the tool and may require more analysis/actuarial service;
 - Contract negotiations with CDDOs to use the new tool;
 - CDDOs will also need time for hardware readiness to allow assessors to complete training and certification; and
 - Managed care organizations (MCOs) will need approximately 12 to 18 months to prepare for implementing the full care planning tool in Kansas.
- A request was made to the MCOs for the average monthly expenditure for transportation provided under the I/DD waiver and the number of individuals

spending under that average. The community support waiver could have a transportation spending cap and the average monthly expenditure would help inform what that cap could be:

- Stephanie Rasmussen, Vice President of Long Term Services and Support, Sunflower State Plan (Sunflower), noted as follows:
 - Because transportation, other than Non-Emergency Medical Transportation, is not a covered Medicaid benefit, the MCOs do not have information on utilization. Sunflower does have a value-added benefit for transportation to job interviews, but this has low utilization and would not be representative of the potential use if transportation is covered under an I/DD waiver.
 - Ms. Rasmussen shared the request with KDADS. She also shared the request with InterHab, as there are I/DD day and residential providers that charge the persons they serve a transportation fee. She indicated InterHab may have an estimate on number of trips for day services, employment, community activities and other types of transportation not currently covered by Medicaid.
 - Sunflower received information from one large provider indicating what they charge members for transportation to and from day services. The provider said they charge \$55 per month for persons that need rides to and from day services. For persons that only go 1-2 days a week, they charge \$27.50 per month.
- Mr. Fletcher (InterHab), in response to the request for the estimate of I/DD service provider transportation costs, noted it would require more than the time given to provide a usable analysis of costs. He noted InterHab would be happy to participate in such an effort if given a longer time horizon for project completion. However, Mr. Fletcher shared a number of considerations InterHab's members felt were important in any consideration of transportation costs:
 - Ideally, an HCBS Transportation system should integrate well with Non-Emergency Medical Transportation and Public Transportation resources.
 - Consider using an approach that does not solely rely on current HCBS provider capacity. Many HCBS support providers in Kansas do not provide transportation services currently and they should not be relied upon to form or expand a program to meet all possible needs.
 - Transportation is not built in to any current I/DD Waiver service except Supported Employment, so current capacity is not robust.
 - Base the rate on “real costs” that include: a competitive wage for drivers, differential rates for distance covered (under 10 miles, 10 to 20 miles, 20+ miles), and separate rates for Ambulatory and Non-ambulatory transportation.
 - Non-ambulatory rates should include real costs of Paratransit, as well as incentives to increase capacity for Paratransit. Paratransit is the most expensive and hardest to get form of Transportation for the HCBS population.

- Transportation providers should be allowed to bill the same rate for everyone in a vehicle, up to a certain limit and should not be required to divide the benefit across riders.
 - One “trip” is one-way. The way back is considered another “trip.”
 - To arrange for the service, Targeted Case Managers should be relied upon to identify and document transportation providers in Person-Centered Support Plans.
- Mr. Fletcher also provided the current established rates for HCBS transportation in Missouri, should they be useful for the Special Committee’s reference:

Range	Services & Modifications	Rates per One-way Trip (based on driver wage of \$18.13)
0-10 miles	Ambulatory	\$11.63
	With non-ambulatory modifications	\$25.09
10-20 miles	Ambulatory	\$21.02
	With non-ambulatory modifications	\$45.72
20+ miles	Ambulatory	\$29.02
	With non-ambulatory modifications	\$63.56

- A request was made for the specific counties where CDDOs are inconsistent in the I/DD assessments. Names mentioned by various roundtable members at the October 13 Special Committee meeting included Johnson County, an unnamed southeast Kansas county, and Shawnee county:
 - No additional specific CDDOs were provided by Roundtable members. The following is a compilation of general comments received:
 - No malice is intended by the CDDOs. There is a lack of consistency in the oversight and process for the processing of eligibility applications. The processes and procedures are not uniform. The desired goal is for the Community Support Waiver to be equitable across the state.
 - Caution was expressed against looking for the outlying counties only on the presumed deficit side of the question. Counties on the other end of the spectrum, or overly efficient counties, are also going to throw off the overall quality and equity of the assessments.
 - One proposal made was, if the goal is to make the assessment application uniform and equitable, that the question should be approached as “how do we get everyone to do it the same” rather than “who is not doing it well enough or correctly.” The result would be a more balanced application to ultimately improve the

desired counties, while keeping the counties who are truly doing the assessment well stable. The areas with fewer resources are going to likely resist change, especially if they are being singled out as “not good enough,” even if that is not the intended message.

- If the assessment application is approached from the standpoint of all CDDOs starting from the same place with this new concept and looking for what each area needs to be uniformly successful, it is likely less push back will be received from those targeted to improve and more willingness to learn a new methodology.
- Advocates have statewide concerns in multiple CDDO regions regarding inconsistent application of eligibility and crisis criteria. The Waiting List Study, for instance, will be analyzing crisis data and should be able to provide more immediate information on state and regional trends in crisis. Obtaining the information listed below will help the Special Committee answer the question regarding inconsistency in how some CDDOs apply the I/DD assessments to determine I/DD waiver eligibility:
 - Does KDADS do Quality Assurance (QA) audits of eligibility determinations or appeals?
 - Is there a list of I/DD eligibility appeals cases, and can these be examined to determine if certain areas are more represented or for patterns in the types of appeals?
 - What does training for CDDO eligibility staff look like? Is there any demonstrated interrater reliability?
 - What are the required credentials of CDDO eligibility staff to interpret complex psychological documents? Do CDDOs contract with a qualified psychologist or other professional to assist in interpretation?
 - Can we get a list of CDDO eligibility staff and their training/credentials?
 - Which CDDOs require an IQ of 70 or under, and which CDDOs interpret eligibility by looking at functional criteria rather than IQ?
- A recommendation was made that the Special Committee examine Missouri’s Regional Centers and the role they play in eligibility determination.
- Some CDDOs seem to require a 70 or under IQ and some CDDOs correctly look at functional eligibility, which is something that should not be arbitrarily required.
- There is significant inconsistency on how crisis/*Olmstead* criteria are applied in the various CDDO areas.
- It is the job of KDADS to manage the waiver and KDHE to manage Medicaid and ensure access (both eligibility and crisis) is uniform statewide. Likewise, it is required that CDDOs must ensure uniformity by doing QA and promote the uniformity through

providing training. It is also a Medicaid requirement that Medicaid recipients have equal access to Medicaid programs like the HCBS Waiver no matter where they live in the state. There is concern this is not happening.

- The Department for Social and Rehabilitation Services (SRS), which now operates as part of KDADS, reduced the number of assessors from approximately 600 to 100 (circa 2010) by taking the functional assessment duties away from targeted case managers and contracting with the 27 CDDOs to perform the assessments. SRS staff stated by reducing the number of assessors the assessments would become more consistent. By reducing the number of assessors, some consistencies may have been gained, but that is only one variable in the process.
- Shortly after the CDDOs were contracted, SRS conducted roundtable discussions that included nearly 100 individuals. The minutes from these roundtables were placed on the SRS website and are still on the KDADS website and, in many cases, the minutes contradict the current BASIS Manual.
- From the beginning, training for CDDO assessors was minimal and has been nearly nonexistent except for an annual online training tool, which is out of date. In fact, several questions in the online training tool have to be answered incorrectly to pass the test.
- The funding and tier reimbursement rates for the community service providers are tied to the outcome of the assessments. The lack of training and the lack of a manual with interpretive guidelines across the state can lead to inconsistencies in how the assessment is done. Regardless of the assessment tool used, a consistent and robust training program is needed. A manual with interpretive guidelines, used by every CDDO and every assessor across the state, is imperative.
- The vast majority of CDDOs are also community service providers. This is an inherent conflict of interest. While many of these CDDOs have a separate name and office space for the CDDO staff, they still have the same management and the same board of directors.
- While in agreement that the assessment tool used in the state is deficit-based, in order to assess the service needs of an individual, the tool has to identify the abilities they have and the abilities they do not have. Whatever functional assessment is decided upon, it needs to take a more positive approach, but there still may be some questions that are deficit-based in order to determine the service needs of the individual.
- As long as funding is linked to the functional assessment process, there will be the possibility of conflict between the organization performing the assessments and the community service provider. KDADS, at times, may need to become involved with a CDDO and community service providers to resolve interpretations of certain

questions within the assessment tool. However, community service providers should not be able to appeal the results of the functional assessments. With this type of process, there is need for a functional assessment tool, a manual, interpretive guidelines, and a robust training program for assessors as they come and go to have the consistencies all desire.

- A request was made to KDHE for the number of individuals in Kansas in the Medicaid buy-in program:
 - KDHE noted it publicly posts eligibility enrollment data in the Medical Assistance Report, such as the [FY 2023 edition](#). As of August 2022, there were 1,234 members in Medicare buy-in programs (985 in Working Healthy and 249 in Working Healthy/WORK).
- A request was made to KLRD staff to contact the states discussed in the October 13 Special Committee meeting that have added or expanded the I/DD programs to ask about their cost. The following responses were received:
 - **Ohio:** Steve Beha (Deputy Director, Chief Policy Officer, Division of Policy and Strategic Direction, Ohio Department of Developmental Disabilities) noted:
 - This table shows total claims for each technology service available in our HCBS waivers. This represents total claims and does not separate state and federal portions of payment.

Program Name	2020	2021	2022	<i>Program Total</i>
<i>Assistive Technology</i>	\$1,835,589	\$2,448,068	\$2,569,920	\$6,853,577
<i>Equipment</i>	5,129,919	4,927,171	4,272,516	14,374,605
<i>Remote Support</i>	9,442,175	13,204,987	15,775,524	38,422,697
<i>Annual Total</i>	\$16,407,683	\$20,265,226	\$22,617,960	\$59,650,879

Initiative	2015	2016	2017	2018	2019	2020	2021	2022	2023 YTD
<i>Tech First</i>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$929,149	\$1,094,074
<i>Employment First</i>	\$3,240,319	\$5,205,745	\$4,601,373	\$4,523,838	\$2,836,530	\$3,875,573	\$3,666,261	\$3,954,362	\$3,455,429

- For context, a large portion of the Employment First funding goes to Opportunity of Ohioans with Disabilities (Vocational Rehabilitation) and draws down their federal dollars towards employment counselors.
- The cost of Employment First in 2014 was \$931,066.
- A request was made for an estimate of the cost to add the 30 percent of children with disabilities not on Medicaid because of parental income and include them in one community support waiver:

- KDHE response pending.
- A request on what is required to amend a waiver versus creating a new waiver:
 - KDHE and KDADS will make a joint presentation on this topic at the November 1, 2022, meeting.