DHHS RESPONSE TO QUESTIONS FROM THE FISCAL RESEARCH DIVISON REGARDING PERSONAL CARE SERVICES /1915i Option

PRESENTATION TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

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TOPIC: PCS/ 1915(i) Option Questions:[1]

FRD Question 1. What is the proposed maximum number of PCS hours allowed under the 1915(i) option and how does that compare to the amount under the PCS model?

DHHS Response: The proposed maximum number of hours under the 1915(i) waiver for PCS services for eligible individuals 21 years and older will continue to be 80 hours.

FRD Question 2. What percentage of adult care homes will be able to meet CMS' standards for Medicaid funded home and community-based services upon the initiation of the new 1915(i) option services?

DHHS Response: DMA does not currently know how many adult care homes (ACHs) will not meet the Center for Medicare and Medicaid Services' (CMS) Home and Community Based Services (HCBS) standards. DMA will distribute the HCBS characteristics to the provider community no later than April 30, 2012 and provide training opportunities regarding the characteristics by May 30, 2012. All ACHs will have to attest to DMA whether or not they meet the CMS standards by June 30, 2012. At that point, DMA will have a better picture of how many adult care homes will be affected.

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[1] **Note for clarification: Despite previous references to the 1915(i) option as the 1915(i) waiver, it is not a Medicaid waiver program. It will be implemented as a State Plan Amendment (SPA) and is available to anyone enrolled in the Medicaid program who meets the eligibility criteria. The 1915(i) option does allow states flexibility in the design of service eligibility, allowing DMA to "waive" some requirements of regular State Plan-offered services. For consistency, DMA has changed references to the (i) waiver in this document to the 1915(i) option.**

FRD Question 3: What are DMA's plans should CMS not extend the April 30th deadline and the 1915(i) option has not been approved?

DHHS Response: DMA received approval of its State Plan Amendment (SPA) NC 12-005 on April 4, 2012. The approved SPA extends the PCS program through December 31, 2012, contingent on adherence to the corrective action plan **(see Attachment A)** also approved by CMS on April 4, 2012. The corrective action plan outlines the steps DMA must take to make its PCS program comparable regardless of setting, addresses the issue of residents of ACHs living in possible Institutions for Mental Disease (IMDs), and transitions the current authority for the PCS program from a regular State Plan service to the more flexible 1915(i) State Plan authority.

Major milestones of the corrective action plan include:

- Identification of the first 25 Institutions of Mental Disease (IMDs) housing PCS recipients by June 30, 2012
- Submission of final 1915(i) SPA for approval to CMS by April 30, 2012
- Transition of recipients in IMDs to alternative housing options by April 30, 2012 and ongoing
- Completion of IMD determination on all adult care homes (ACHs) by September 1, 2012
- Determination of individuals eligible for the 1915(i) by November 30, 2012
- Completion of independent assessments in residential settings by November 1, 2012
- Distribution of home and community based services (HCBS) characteristics to providers by April 30, 2012
- Provision of provider training on HCBS by May 30, 2012
- Identification of ACHs who meet HCBS characteristics through attestations due June 30, 2012
- Enrollment of 1915(i) PCS providers by September 1, 2012
- Completion of transition to alternative living situations for recipients by December 1, 2012
- Implementation of 1915(i) PCS services on January 1, 2013

FRD Question 4. In the March 13th presentation, it was stated that 3,700 to 4,000 individuals currently receiving PCS services would become ineligible under the new 1915(i) option, who are these people and what about the criteria in the 1915(i) option would make them ineligible?

DHHS Response:

1915(i) Option Target Population Model

1915(i) Option Target Population	Individuals with Physical Disabilities	Adults with MI, MR/DD, and Dementia Diagnoses	At-Risk Elderly
Population Definition Age, Diagnoses, and Physician-Documented Functional Limitations, Need for Caregiver Availability, and Risks	Medicaid recipients of all ages with a documented medical condition or physical disability (diagnosis) that a physician attests limits the person's ability to independently perform activities of daily living (ADLs).	Medicaid recipients age 18 or older with a documented MI, MR/DD, or dementia diagnosis that a physician attests limits the person's ability to independently perform ADLs. Members of this target population also must require 24-hour caregiver availability, as attested by the physician.	Medicaid recipients 65 years of age and older with physician-documented limitations in functional abilities and risk of falls, malnutrition, skin breakdown, or complications from medication non-compliance.
Eligibility Criteria Established by an independent functional assessment of the person's ADL and IADL needs	Any of the following: 1. Unmet need for hands-on assistance with three (3) ADLs, or 2. Unmet need for hands-on assistance with two (2) ADLs, one of which requires extensive or greater assistance, or 3. Unmet need for hands-on assistance with two (2) ADLs and assistance with Meal Preparation or Medication Management.	Any of the following: 1. Unmet need for hands-on assistance with two (2) ADLs, 2. Unmet need for hands-on assistance with one (1) ADL and set-up/supervision assistance with two additional ADLs, assistance with Meal Preparation, or assistance with Medication Management. 3. Unmet need for set-up/supervision assistance with two (2) ADLs and assistance with Meal Preparation or Medication Management.	Either of the following: 1. Unmet need for hands-on assistance with two (s) ADLs, or 2. Unmet need for hands-on assistance with one (1) ADL and assistance with Meal Preparation or Medication Management.

The 3,700 to 4,000 figure includes the following:

- Approximately 1,350 In-Home Care for Adults recipients whose most recent Independent Assessments do not medically meet ADL criteria described under the 1915(i) primarily for Individuals with Physical Disabilities and secondly for adults with Mental Illness, people with IDD or people with Dementia Diagnoses.
- Approximately 2,000 current ACH recipients who may not meet ADL criteria under any of the three Target Populations.
- Approximately 300 current recipients of group homes for people with MI or IDD who don't meet the eligibility ADL criteria identified in Target Population for people MI or IDD
- The remaining 350 are recipients who have entered the either In-Home PCS, ACHs, Special Care Units or group homes serving people with MI or DD since sampling of ACHs in July, 2011 and review of in-home independent assessments in November, 2011. All programs have continued to increase admissions.

The estimate that 10 percent overall would not qualify under the Target Population model is based on DMA discussion with stakeholders and internal departmental staff, whose input indicates that:

a) the vast majority of ACH residents require 24-hour caregiver availability rather than deficits in ADL models;
b) most require assistance with meal preparation and/or medication management;
c) most elderly residents are at risk for falls, malnutrition, skin breakdown, or medication noncompliance without supervision and assistance from ACH staff; and
d) residents who do not have many hands-on ADL needs generally require ADL set-up, supervision, or cueing.

When present, these limitations and risks would enable residents who do not have the hands-on ADL needs described under Target Population A to qualify for services under B or C. These factors are not documented on the recipient care plans that DMA sampled in sufficient detail to develop more precise estimates.

NOTE: In July 2011 DMA randomly selected 500 recipients care plans of recipients living in ACHs with paid claims for dates of services of March 2011. At the end of November 2011, DMA reviewed 327 randomly sampled ACH recipient care plans as provided by the providers, which showed that 60 percent would not meet a two hands on ADL criterion, and 69 percent would not meet a three hands on ADL criterion. (Comparable estimates for recipients in Special Care Units were 19 and 39 percent, respectively.)

FRD Question 5. It was noted that those who are to be eligible for services under the 1915(i) option would have to have needs that are not as great as those who are ICF-MR eligible. Current CAP-MR/DD as well as Innovations recipients must meet the ICF-MR eligibility criteria. Does this mean that none of the people currently receiving CAP-MR under the Supports or Comprehensive Waiver or those under the Innovations waiver will be eligible for 1915(i) option funding?

DHHS Response: Yes. The 1915(i) option will provide PCS for people who require a lower level of care than those receiving services through the Community Alternatives Program (CAP) waivers. The CAP waivers require that individuals meet an institutional level of care – an ICF-MR, nursing facility, or hospital level of care. The 1915(i) option cannot be provided in an institutional setting and does not provide services at an institutional level of care.

Individuals currently receiving services through the CAP programs will continue to receive PCS services provided by the waiver, not through the 1915(i) option. They will see no difference in their services due to the implementation of the 1915(i).

FRD Question 6. How will the 1915(i) option be coordinated with the operation of the B-C Medicaid waiver?

DHHS Response: The 1915(i) option **does not** impact the operation of 1915(b)(c) waivers.

The 1915(i) option for people with mental health, substance abuse, or developmental disabilities has not been included in the capitation payments for the 1915(b)(c) waivers. It is considered a carved out service.

FRD Question 6 a. If all funding for services for people with MI-DD or SA disease is to be managed via the MCOs as is directed in H916, wouldn't this be included under that?

DHHS Response: No. The 1915(i) PCS service is a stand alone Medicaid service and is not available to people who participate in CAP programs due to level of care eligibility. However, if a physician and an independent assessment determine that a recipient without a CAP slot - regardless of their MI-DD or SA diagnosis - needs personal care services, the recipient will receive PCS just as they would any other medical service. PCS is not viewed as a behavioral health service.

FRD Question 6 b. Who will provide care coordination and be responsible for provider qualifications etc. for this population?

DHHS Response: Care coordination for Medicaid services remains with Community Care of North Carolina (CCNC) and the corresponding LME/MCO for behavioral health, developmental disability and substance abuse services. DMA, in collaboration with other DHHS divisions such as the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Aging and Adult Services, is responsible for establishing provider qualifications and the Division of Health Services Regulation is responsible for licensure.

FRD Question 7. Will the only service authorized under the 1915(i) option be PCS?

DHHS Response: Yes, PCS is the **only** service authorized under the 1915(i) option at this time.

FRD Question 7a. If there are other services, what are they?

DHHS Response: There are no other services planned at this time.

FRD Question 8. Is there any restriction for where an individual must or may live to be able to receive 1915(i) option funded PCS services?

DHHS Response: PCS services provided by the 1915(i) option may be provided in private homes by licensed agencies enrolled in the Medicaid program or in licensed residential settings enrolled in the Medicaid program that meet CMS' HCBS standards and are not classified as Institutions for Mental Disease (IMD, a facility with > 16 beds and 50% of residents with a mental health issue as their primary diagnosis).

FRD Question 8a. Could an individual live in a 32 bed adult care home?

DHHS Response: Yes, as long as that ACH is licensed by DHSR, enrolled in the Medicaid program, meets CMS' HCBS standards, and is not an IMD.

FRD Question 8b. Incarcerated?

DHHS Response: No, people who are incarcerated are not eligible for Medicaid except for inpatient medical care received in regular inpatient hospitals as long as they meet the eligibility criteria.

FRD Question 8c. DOJ is interested in assuring that people with IDD do not receive CAP-MR services if they live in greater than 4 bed settings, will this be the same for 1915(i) option recipients?

DHHS Response: The limitation of the 1915(i) option is that it must be provided in settings that meet home and community based services (HCBS) characteristics. Although CMS has discussed the 4 bed limit, the 1915(i) option **does not** limit based upon bed size of a facility.

FRD Question 9: The eligibility requirements are unusually broad. For IDD this service will become a new entitlement to service and potentially extraordinarily costly to the state. Has there been any thought given to administration of the Supports Intensity Scale to those potentially eligible for the purpose of including them in the "continuum of care" matrix, assuring that the independent assessment is accurate per their disability then allowing allocation of resources to be managed in a planned approach? That is, those who show up for service may be eligible for the 1915(i) option, or may need a more complex array of services per the CAP-MR/DD waiver. Others on the CAP-MR/DD waiver may best be served via the 1915(i) option etc. This would seem consistent with the desire to assure that services are fairly allocated to address needs, no more and no less.

DHHS Response: Individuals receiving services through the CAP-MR/DD waiver must meet an intermediate care facility for persons with mental retardation (ICF-MR) level of care. Individuals with a high level of need would not be better served by the PCS-only level of care provided under the 1915(i).

The Supports Intensity Scale (SIS) will be administered for all individuals with developmental disabilities regardless of type of Medicaid services utilized. If PCS under the 1915(i) is the appropriate level identified, this referral would be made. An independent assessment to determine need for assistance with activities of daily living will determine the number of hours of personal care services the individual should receive. The SIS should inform the 1915(i) independent assessment.

FRD Question 10. In the eligibility category that includes MI and I/DD, you also include other cognitive impairment, are you intending to include those with acquired brain trauma, anoxia and stroke or only those with dementia and/or Alzheimer's?

DHHS Response: The eligibility criteria are based on cognitive impairment as determined by the referring physician and the independent assessment of needs related to activities of daily living. It would not exclude any specific cause of cognitive impairment.

FRD Question 11. How did you determine the potential number of persons who may become eligible for and want to take advantage of the 1915(i) option? The "woodwork" group?

DHHS Response:

Numbers are approximations	Enrollment	Appeals	Woodwork
In-Home	929 (growth in Medicaid enrollment)	675 (50% of people who don't meet eligibility criteria will file appeal and thus will be eligible for Maintenance of Service or will receive service as a result of the final agency decision)	6,245 (17.5% factor applied to anticipated total PCS program enrollment and applied per rata between place of settings)
ACH	526 (growth in Medicaid enrollment)	127 (50% of people who don't meet eligibility criteria will file appeal and thus will be eligible for Maintenance of Service or will receive service as a result of the final agency decision)	4,147(17.5% factor applied to anticipated total PCS program enrollment and applied per rata between place of settings)

FRD Question 12. Will the rate paid for PCS under the 1915(i) option be the current in-home rate? Will family members be able to be paid for providing PCS under the 1915(i) option?

DHHS Response: The rate and payment methodology is still to be determined. Once established, payment rate and methodology will be the same across settings.

Family members will not be paid for providing PCS under the 1915(i) option. Families **are not currently** paid as caregivers under the current PCS In-Home program.