Joint Legislative Oversight Committee on Health and Human Services
Update on
Personal Care Services & Institution of Mental Disease

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Personal Care Services (PCS) Background

Session Law 2012-142, HB 950:

- Personal Care Services (PCS) benefits for children and adults
- Consolidates services for recipients in private residences and adult care homes, group homes, and combination facilities
- Extends Independent Assessment (IA) requirement to recipients in licensed homes
- Raises PCS eligibility requirements for recipients in licensed homes to same level as private residences
- Eliminates essential errands as an allowable use of PCS services
- No other impact for recipients under 21 years due to EPSDT requirements – a federal requirement that each state must follow that requires services be provided to correct or ameliorate conditions and meet conditions of section 1905a of the federal rules.

PCS Eligibility

Eligible adult recipients:

- Have medical condition, disability, or cognitive impairment, *and*
- Require limited hands-on assistance with three activities of daily living (ADLs), or hands-on assistance with two ADLs including one at the extensive assistance or full dependence level

Qualifying ADLs are:

bathing, dressing, mobility, toileting, and eating

Status of Implementation

SPA to change PCS eligibility:

- **July 20, 2012—**DHHS applied to CMS for a Medicaid State Plan Amendment (SPA) to implement the required legislative changes

Consolidated Personal Care Services policy:

- **July 18, 2012—**Proposed Medicaid Clinical Coverage Policy 3L, Personal Care Services (PCS), was posted for 45-day public comment period (end date Sept 1, 2012)
  - Proposed Policy 3L includes all provisions specified in SL 2012-142.

Status of Implementation *cont'd*

Independent Assessment Vendor:

- **July 1, 2012—**DMA extended Independent Assessment (IA) contract with The Carolinas Center for Medical Excellence (CCME) through June 30, 2013
  - CCME has been conducting the IA for the in-home program
  - This amendment allowed for the immediate implementation of IA for recipients in facilities, leveraging existing cost and resources in place for the in-home program
- A Request for Proposal (RFP) is under final clearance to identify an IA vendor who will conduct both the in-home and facility PCS
  - Release of RFP is anticipated for September 2012
  - Effective date of new contract:
    - January 1, 2013 for a planned transition period with current vendor

Status of Implementation *cont'd*

Independent Assessments:

- IAs of In-Home Care (IHC) recipients are up to date.
  - Ongoing IHC assessments will determine eligibility for transition to PCS effective Jan 1, 2013
- IAs in Adult Care Homes and other facilities began July 23, 2012
  - IAs have been scheduled thru Aug 20th accounting for 6,020 people
  - IAs completed thru Aug 3rd is 1,614
  - Target date for completion remains Nov. 30, 2012 as required in the CMS approved Corrective Action Plan

Status of Implementation *cont'd*

Projected impact of new PCS eligibility criteria:

- Raises entrance criteria for licensed adult care home recipients
  - Number with primary mental health diagnosis is not known since the IMD determinations have not been completed
- No change in eligibility for in-home recipients

Status of Implementation

Projected impact on licensed facility residents

Setting	Qualifying Recipients	Non-qualifying
SCU	1,843 (73%)	685 (27%)
ACH/FCH	5,571 (36%)	9,903 (64%)
Group Homes [*5600c (IDD)]	166 (14%)	1,059 (86%)
Group Homes [5600a (MI)]	Near 0 (0%)	Near 994 (100%)
Total	7,580 (37%)	12,641 (63%)

Status of Implementation

- Projected indirect impact on In-Home Care recipients

Setting	Qualifying Recipients	Non-qualifying*
In-Home Care	21,941 (88%)	2,893 (12%)

*Includes current IHC recipients who do not meet current program eligibility criteria and are authorized through maintenance of service, settlements, or Pashby class activity

Institution of Mental Disease Update

What is an IMD?

- IMDs are defined as “a hospital, nursing facility or other institution of **more than 16 beds** that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services” (42 CFR 435.1009)
- An institution is considered an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such
- An institution for the mentally retarded is not an IMD. However, facilities **for the treatment of substance abuse are considered IMDs**
- More than 50% of all the patients in the facility will have a current need for institutionalization resulting from mental diseases. In applying the 50% guideline, *North Carolina needs to determine if the primary diagnosis of mental health is the reason for living in the residential setting*

IMD Exclusion

- The IMD exclusion applies only to institutions (facilities) with at least 17 beds or are deemed to have more than 17 beds due to shared ownership.
  - There are criteria used to determine shared ownership

- Medicaid match is **not available** for any services provided to beneficiaries who are residing in an IMD (1905(a) of the Social Security Act) except in limited conditions which the facilities being reviewed do not qualify
  - Beneficiaries under age 21 and over 65 in nursing homes or impatient psychiatric hospitals.

Residential Facilities
Phase II IMD Process

Determining if a Residential Facility is an IMD

Define the institution – which means what facilities are being examined

Are there 17 or more beds in the institution?

YES

Is the current need for institutionalization of 50% or more of residents (using licensed beds) a direct result of a mental health/substance abuse illness being the reason for the placement? Is the overall character of the facility is primarily for the care and treatment of individuals with MH/SA?

YES

The institution is an IMD

NO

NO

The institution is not an IMD

IMD Settlement Tiffany v. DHHS/DMA

- DHHS agreement with the North Carolina Association, Long Term Care Facilities and a group of twenty-five adult care home providers
- The agreement includes
  - IMD determination process agreed upon by NCALTCF, counsel for the adult care homes and DMA
  - OAH petition was withdrawn
  - ACHs waived the argument that DMA was required to promulgate rules before starting the IMD investigations.
  - The twelve facilities which previously received notification that they meet IMD criteria were allowed to present additional documentation to DMA. DMA reviewing each submission to determine if this information changes DMA's original determination. Final decisions will be issued on or before August 1
    - This August 1 date is impacted by current discussions with CMS requiring licensed or occupied beds
  - Any adult care home that is ultimately found to be an IMD has the right to file a new petition at OAH to challenge the IMD determination, including whether DMA correctly followed the process set out in CMS State Medicaid Manual section 4390 and the PowerPoint Presentation agreed to by the parties

Phase I Activities 2011

September - December 2011

- 25 homes were identified
  - Letters sent to providers notifying them of the screening
  - DMH/DD/SAS and DMA conducted training on IMD processes and expectations with LME and CABHA
  - Clinical Assessments for individuals were initiated

Phase I Activities 2012

January – March 2012

- All data uploaded into database
  - Included clinical assessments, medical records, and facility assessments
- DMA review panel convened
  - Clinical (medical and behavioral health) and administrative staff (DMA and DMH/DD/SAS)
  - Reviews data weekly
  - Decides any At Risk and IMD determinations
  - At Risk Providers identified

Phase I Activities 2012 *cont'd*

April - June 2012

- 16 of 25 original homes required additional information on possible shared ownership
  - Initiated phone interviews with owners to determine shared ownership
  - Letter sent to owners addressing shared ownership
  - Additional homes identified as a result of possible shared ownership
  - Additional At Risk letters send to providers
  - On site reviews initiated May 29-30
  - 1 Facility designated IMD on June 7
  - Transition teams sent to IMD facility for discharges
- DMH/DD/SAS completed housing analysis
- Temporary Restraining Order (TRO) filed (Tiffany v. DHHS/DMA) June 15
- The home identified on June 7th as an IMD facility was reinstated June 25th
- IMD Provider training was scheduled for June 27th, but requested by industry to reschedule for July.

Phase I Activities 2012 *cont'd*

July - August 2012

- 12 homes were deemed IMD on July 5th
- Letters were sent to providers with effective date of July 9th
- Recipient letters were held
- IMD Provider training conducted July 11th primarily for 131D facilities licensed
- Additional IMD provider training was conducted July 19th for 122C licensed facilities
- DMA received modified instructions from CMS on occupied beds. We are continuing to work with CMS on revised methodology and will issue final decision once we have agreement with CMS
- The revised methodology affects the timelines for Phase II completion - thus modifying the plan of correction

Phase I Results & Impact To Date

- Of the original 25 facilities previously identified to be “At Risk” in Phase I, 13 facilities received letters indicating they are found to be an IMD
  - The TRO stopped 12 of the facilities from final notice
  - No notices have been distributed for the 12 facilities
- Total occupancy in 13 facilities = 533
- Total residents identified with primary diagnosis of mental illness/substance abuse = 283
  (excludes IDD, TBI, Dementia, Alzheimer, Organic Brain Syndrome)

Phase II Activities and Data

- Complete a current data run of existing ACH, MH Group Homes, Family Care Homes by site and tax ID to determine any additional homes
- DMA received modified instructions from CMS on occupied beds. We are continuing to work with CMS on revised methodology and will issue final decision once we have agreement with CMS
- Data elements include
  - Residential settings licensed as an 122C or 131D facility billing PCS services
  - 6 months review of paid claims by any provider who billed Medicaid using a MH/SA diagnosis for the person living in a facility above
  - Identify 1 month within the above data period to identify unduplicated beneficiary count living in the facility
  - Provider EIN (tax ID number) used to determined possible shared ownership

Phase II Data

Screening of Facilities

Any recipient with at least one claim in 6 month period

Calculate the > 50% by:

- Numerator: Primary MH/SA diagnosis
- Denominator: One month of unduplicated claims (*)
- Licensed beds per NC Division of Health Service Regulation to determine >16 beds as single or a shared ownership

Conduct phone interviews to identify shared ownership

Conduct onsite review

IMD At Risk/ Determinations

Numerator: # of Primary reason for living in residential setting

Denominator: Occupied beds(*)

(*) pending negotiations with CMS

Phase II - Projection of Facilities to be Reviewed for IMD

- Once DMA finalizes methodology with CMS for occupied beds, DMA will run final data for Phase II
  - Very preliminary number is 135; this number is expected to increase as the data analysis is fine tuned

- Formal communication regarding change in methodology to the providers has not happened
  - Preliminary conversation has occurred with leaders of the industry
  - Once final determination is complete with CMS, written notification will occur to all providers

Phase II - Discharge Process for Consumers and Facilities

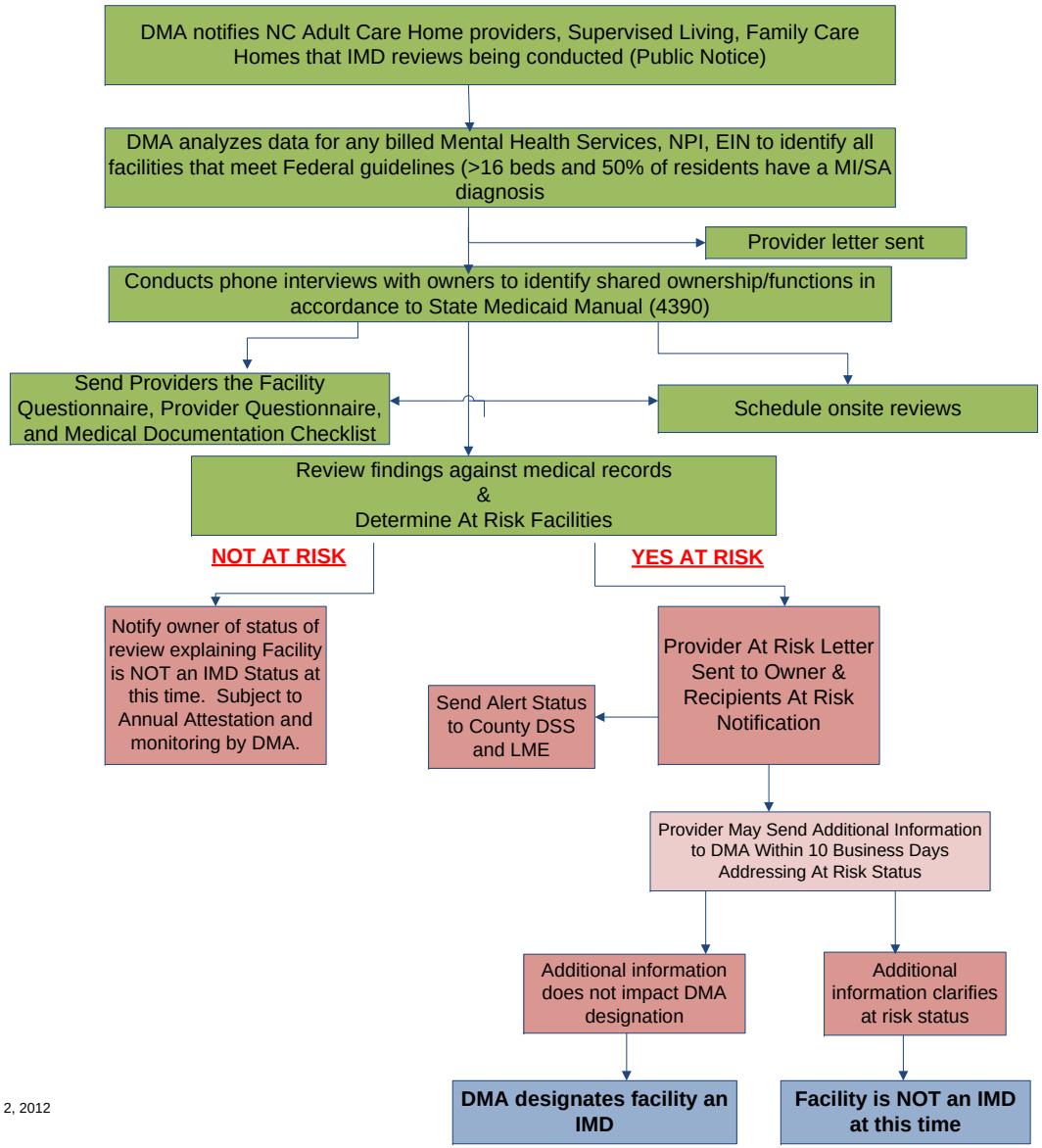
(At Risk or Documented as IMD)

- DMA PCS eligibility criteria, IMD determinations or IMD At Risk activate potential or actual discharges of recipients due to
  - PCS ineligibility
  - At Risk facilities for IMD
  - IMD determinations

Phase II IMD Discharge Process

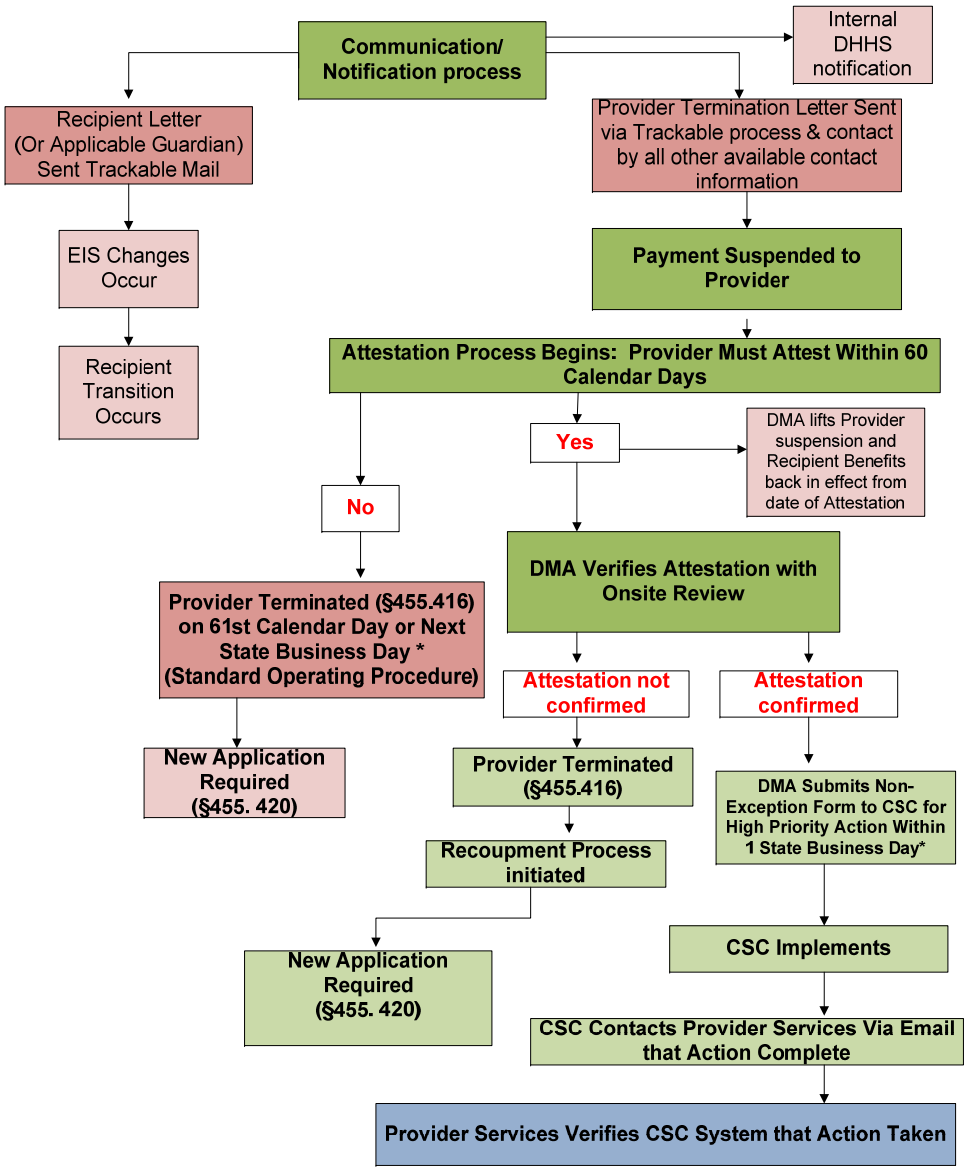
- DMA designates At Risk and IMD determinations
- DHSR insures compliance by Facility to discharge according to rules
- DMH/DD/SAS coordinates discharges for individuals with MH/SA
- DSS coordinates for all other recipients
- DHHS has emphasized the importance of local agencies and communities being proactive in planning and activation of resources to assist with relocation of recipients
- LME and DSS sent notification of facility status and list of recipients via secured email
  - Disability Rights of NC will also receive notice of the provider IMD determination
- Recipients' legally responsible person and guardians should be actively involved in the transition/discharge process to insure choice for housing options in community and to address continuity of care and health/safety of the recipient
- Complaints may be routed to Regional Ombudsman or through DHSR Complaint Intake Unit.

North Carolina DMA IMD Determination



North Carolina DMA IMD Determination (page 2)

Facility Designated IMD



Communication to Impacted Parties

- Training conducted
  - July 11th with >350 participants
  - July 19th with >250 participants
- Ongoing Stakeholder meetings since March 2011
- Presentations at conferences and meetings (available on website at http://www.ncdhhs.gov/dma/)
- Recipients/guardians receive notification letters at the time of provider designation of At Risk status and final IMD determination.
- FAQ on the DMA website

Who is Responsible for IMD Assessments in the Future?

- Facilities licensed under GS 131D or 122C will submit annual attestations stating compliance with IMD requirements
- DMA will select on a random basis site reviews to validate attestations
- Final decisions have not been made regarding the addition of IMD reviews as part of other compliance/ licensure reviews that facilities must have
- Federal law prohibits the delegation of IMD determination outside of the State Medicaid Agency