Presentation to The Blue Ribbon Commission ACH Transition Subcommittee

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Tara Larson, Chief Clinical Operating Officer

Division of Medical Assistance

Overview of the Issues

- IMD (Institutions for Mental Disease)
  - Issue: CMS concerns that some adult care homes may have so many residents with mental health that the character of the institution may have changed their federal status to an IMD. CMS generally does not pay for disabled adults living in IMDs. Another DHHS presenter will explain this issue more fully and give the current status.
- PCS (Personal Care Services)
  - Issue: CMS requires that Medicaid services be comparable in all settings. CMS contended that the way NC operated its PCS service was not comparable. Similarly, a recently filed lawsuit contended the same. The General Assembly addressed the issue by setting new eligibility criteria that apply equally to all individuals. Another DHHS presenter will explain this issue more fully and give the current status.
- US DOJ's Concerns and the Recent NC Settlement Agreement

Update on IMD Since the September 5th Blue Ribbon Commission

- CMS required a change in methodology for determining the 50%. CMS changed the denominator from licensed beds to occupied beds. CMS approved this submitted change
- Phase II of the reviews will begin this week
  - Approximately 151 facilities have been identified
  - The first step will be to review the ACHs
    - ACHs identified based upon the approved methodology
    - 38 ACHs with a single tax ID
    - ACHs and other facilities may be identified through review of shared ownership (example, separate tax ID but same owners)
  - Includes single entities or entities identified through shared ownership

IMD Update (cont.)

- DMA continues to have conversations with CMS about the Plan of Correction timelines for completion of the IMD reviews. Proposed dates submitted to CMS are:
  - ACH reviews to be completed by 11/30/12
  - Family Care Homes by 2/28/13
  - 122c Group Homes by 6/30/13
  - Family Care Homes or 122c group homes on the same property by 11/30/12
- DMA will publish an initial list of ACHs that lists both single entity facilities and facilities that are linked through ownership or tax IDs that meet the 50% threshold in some manner.
  - The shared ownership review must occur in order to determine if the facilities or facility operate as one entity

IMD Update (cont.)

- Shared ownership -State Medicaid Manual (SMM), Section 4390
  - Are all components controlled by one owner or one governing body?
  - Is one chief medical officer responsible for the medical staff activities in all components?
  - Does one executive officer controls all administrative activities in all components?

  NO TO ANY OF THE ABOVE QUESTIONS MAY INDICATE A SEPARATE FACILITY
  - Are any of the components separately licensed?
  - Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
  - If two or more of the components are participating under the same provider category (such as NFs) can each component meet the conditions of participation independently?

  YES TO ANY OF THE ABOVE QUESTIONS MAY INDICATE A SEPARATE FACILITY

- Single entity means the 50% is based upon the occupancy and MH/SA count of the one facility. If shared facilities are deemed to operate as one facility then the 50% is determined using the combined total of the facilities.

IMD Determination to Date

- Four (4) facilities were deemed IMD with effective date of September 17th and facilities filed with OAH for a temporary restraining order
- OAH entered a preliminary injunction of October 1, 2012, which prevents the Department from implementing the IMD determinations that were made as to the four (4) Adult Care Homes
- The determinations were based on a finding that that all 4 facilities had the overall character of an IMD because large proportion of the beneficiaries received psychopharmacological drugs, more than 50% were in the ACH because of MH/SA and because the facilities provide "related services" (including PCS, medication management, and supervision) to the individuals.
- This preliminary decision by OAH was based on the finding that ACHs do not provide MH treatment and psychopharmacological drugs are not enough.
- The preliminary injunction does not prohibit moving forward with Phase II of the IMD review process as required by CMS

Questions about IMD?

Personal Care Independent Assessments (IAs)

- The purpose of the assessment is to assess functional status of recipients of Activities of Daily Living (ADLs):
  - Bathing, dressing, toileting, ambulation, and eating through natural or simulated demonstration by the recipient
  - The need for hands-on assistance is the determining factor for meeting the eligibility requirements
  - The degree of hand-on assistance needed (limited, extensive or full) drives the authorized service amount
  - The assistance levels and methodology are consistent with the levels used in the In-Home PCS program since 2010.
- Changing the methodology of level determination would require modification to clinical policy, IT system changes and "re-running" eligibility for all recipients (in-home and facilities)
  - Fiscal impact

Personal Care Independent Assessments (IAs)

- The assistance levels and methodology are consistent with the levels used in the In-Home program since 2010
  - Requirements for comparability of services offered in different settings mandates consistent methodology

Personal Care Independent Assessments (IAs)

- Schedule of Assessments is posted on the DMA website at http://www.ncdhhs.gov/dma/pcs/Projected_IA_Timeline_09172012_Update.pdf
- Provider is contacted by the IA vendor (CCME) at least 2 weeks in advance.
  - Information is given regarding the upcoming assessment.
  - Facilities are faxed a list on recipients on record and asked to review for any changes and to send back to the vendor
  - Facilities are called 24 hours in advance by the nurse assessor who provides specific arrival time for the assessments
  - The assessor does not make eligibility determination – only conducts the assessment

Personal Care Independent Assessments (IAs)

- The nurse asks recipient to demonstrate performance of the 5 ADLs in the area where the tasks normally occur
  - Assessors relay of staff interviews and confirms with facility records (aide assignments, plan of care, nurse supervisory data) to complete ADL information for recipients unable to participate in assessment due to cognitive or physical impairments
  - Statistical data obtained on 9/10/12 indicate that the average length of time to complete the assessment is 54 minutes (for alert, oriented adults time is less)
    - Assessor can also observe multiple ADLs at one time
    - Walking with steady gait into bathroom for demonstration who sits on shower chair, who has full range of motions, states can dressed self, would not got through motion of demonstrating all other ADLs
  - If assessor is not able to observe eating a meal due to scheduling, the assessor is trained to obtain information from the facility regarding preparation, serving and clean up of meals. Recipients may be asked to demonstrate or pantomime the motions required for eating

Personal Care Independent Assessments (IAs)

- Data Entry
  - Standard Assessment instrument
    - Demonstration of ADLs, tasks required, and frequency of need for assistance
    - Other sources of information may be reviewed such as medical records or interviews with family or caregivers
  - Demographic information is pre-populated from the recipient record in the IT tool and other information is entered obtained from the physician attestation form
  - The workflow system for the IA is call QIReport and has been used for the in-home program since 2010.
    - Logic in the IT system along with the data entered based upon the nurse assessment determines the number of hours for the PCS program

Personal Care Independent Assessments (IAs)

- Quality Reviews of Assessments
- All nurses go through training prior to being allowed to conduct assessments
  - All assessments by each RN are reviewed by a specially trained nurse for consistency, validity and compliance with policy and procedure until the QA reviewer determines competency of the RN assessor
  - Incorrect assessments are returned to the assessing nurse for corrections and reviewed again when resubmitted. The process continues until the assessment meets the QA criteria
  - Once the RN assessor has been deemed competent with assessment, he/she continues to be randomly reviewed on 5% of assessments
- DMA monitors the QA via monthly reports and random reviews

Personal Care Independent Assessments (IAs)

- Once the State Plan Amendment is approved, the vendor will begin to send notices of eligibility or ineligibility to the recipients.
  - If ineligible, notice of appeal rights will be included in the notice
  - If the recipient appeals, Maintenance of Service (MOS) will apply if the recipient is already receiving PCS service
  - There is not MOS for recipients not receiving PCS who are applying for PCS
  - No recipients in facilities have received notices of eligibility or ineligible at this point

Personal Care Independent Assessments (IAs)

- Based upon review of the data and reports from providers, recipients who are ineligible for PCS appear to need assistance in the following areas:
  - Assistance with ADLs but not to the current criteria of 3 or extensive/limited
  - Prompting or cueing rather than hands on assistance
  - Training (which is habilitation) on how to do the ADLs
  - Supervision and monitoring
  - A safe place to live
  - Assistance with medication management only
- Once the PCS eligibility notifications have been sent, the local LME/MCO and DSS will also be notified of decision
  - Options for other services or funding
    - State funded services through MCO/LME (not an entitlement)
- Planning continues for 1915i for IDD

Independent Assessment Results to Date

ACH Independent Assessment Results, Current as of October 1, 2012*

SETTING	Assessments Uploaded	PCS Qualifying			PCS Non-Qualifying	
		Count	Percent	Average Approved Hours/Month	Count	Percent
ACH Bed in NF	502	267	53%	**65**	235	47%
Adult Care Home	5756	2869	50%	**66**	2887	50%
Family Care Home	475	167	35%	**65**	308	65%
SLF 5600a	201	34	17%	**60**	167	83%
SLF 5600c	473	135	29%	**64**	338	71%
Special Care Unit	1374	1119	81%	**72**	255	19%
Grand Total	8781**	4591	52%	**67**	4190	48%

*All 10/1/2012 estimates of qualifying and non-qualifying percentages are within +/- 5 % of 8/30/2012 estimates.

**Approximately 13,171 assessments were completed as of 9/28/2012. Table results reflect all uploaded assessments. Additional completed assessments have not yet been uploaded and/or are missing medical attestation forms required to upload and process assessments. To date, medical attestation forms have not yet been submitted for 21 percent of beneficiaries with completed assessments.

Questions about PCS IAs?

Discharge Planning Process and Timeline

- Discharges can be initiated at any time by the family or the facility. If the facility starts the discharge process, there must be 30 day notice and follow the licensure requirements for discharge
- If the family begins discharge, the notice requirements can be waived
  - Many families/recipients have initiated the discharge process
- DHHS is tracking discharges and movement
- DHSR will review the discharges within 2 to 4 weeks of IMD determination and as part of licensure

Discharge Planning Process and Timeline

- LMEs/MCOs and county DSSs are very engaged in the discharge process
- They are informed at the:
  - IMD Screening process
  - IMD At Risk notification (at least 10 days before final IMD determination)
  - IMD final determination (4 to 5 days before effective date)
  - Will be informed about PCS determinations for referral to other services and other possible linkages
- Recipients who have MH/SA/DD diagnosis – the LME/MCO is the lead local agency.
- DSS is the lead for all other recipients

Discharge Planning Process and Timeline

- Roles for DSS or MCO/LME
  - Active planning among local agencies in anticipation of actions – clear expectation that safe placement is first priority
  - LMEs have been asked to develop and submit to DMH/DD/SAS an "Action Plan"
  - Once at risk notification is received, the local entity sets up a face to face with facility administrator
  - Face to face visit includes:
    - Review of letter from DMA
    - Sharing of names of individuals residing in the facility
    - Obtain information about plans the information may have for the recipients
    - Schedule visits for LMEs/DSS to visit with the recipients
    - Obtain name and contact information of guardians/legal representative
    - Obtain names of any individuals who have already been discharged

Discharge Planning Process and Timeline

- Roles/responsibilities cont.
  - Provide contact information (business cards, names, brochures) for those requesting assistance
  - Access the housing database for possible resources for alternative housing options (part of the upfront planning referenced in earlier slide)
  - Active involvement by recipient and guardian in process, using person centered approach and choice as possible.
  - Care Coordination will be provided to recipients with MH/DD/SA
  - Distribution of contact information for other resources
    - Consumer Complaints with DHSR
    - Regional Ombudsman
  - Documentation of tracking/discharge of recipients as well as services provided/established

Discharge Planning Process
Accessing the Community Transition Funding

- How will funds be appropriated?
  - Funding is available only for PCS, not IMD
  - Funding is available for 131D licensed facilities
  - Major Assumptions
    - Exhaust maintenance of services before accessing funds
      - Reconciliation with appeals data and hearings
    - Facility will submit claim to DMA/HP
    - Ongoing coordination with DSS or LME/MCO to ensure continued lack of placement options will be critical
- DHHS work group has met to explore the IT possibilities of payment
  - External membership will now occur

Discharge Planning Process
Accessing the Community Transition Funding

- ACH provides 30 day discharge notice to recipient
  - Request discharge team and transition planning begins
  - Discharge team will certify lack of other placement and will notify DHHS
  - DHHS will flag the claims associated with the recipient and pay the appropriate rate based upon MOS and date of payment (reduced rates over the 6 moths)
  - Transition payments end date of service effective 6/30/12

Questions?