PACA MH/DS
Pennsylvania Association of County Administrators of Mental Health and Developmental Services

Building Blocks in Creating New Community Waiver for ID with County Right of First Opportunity Option

The Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS) has been developing a concept for intellectual disability that would build upon the success experienced with behavioral health managed care in Pennsylvania. The intent is to build upon the strengths of the community intellectual disability service system and available resources to develop a new community service delivery system. In addition to research, PACA MH/DS continues to engage stakeholders to better understand the various roles and functions in a managed care environment. This paper identifies critical components in developing a county option model. PACA MH/DS promotes the County Right of First Opportunity as the means to develop a responsive, effective and efficient community services system. (The Future of Pennsylvania's Medicaid Funding for Services to Individuals with Intellectual Disability, adopted April 25, 2012.)

County Right of First Opportunity

The County Right of First Opportunity is an approved approach for state and federal purchasing. The state creates a set of standards for the program and places them out to bid. Counties' applications are the first to be reviewed for an area covered. If the county proposal meets the standards, they receive the contract without further review of the proposals. The federally funded behavioral health system required administrative entities to assume the risk of cost overruns in meeting the needs of the population covered.

Increased Value

- Ability to create services in addition to required service definitions
- Ability to invest earnings locally as county government may not realize profit
- Ability to create stability across programs for state and federally funded services
- Creates common administrative approach to work with behavioral health for individuals with dual diagnosis of MH/ID
- Keeps local voice and choice in planning and service delivery

Stakeholders

PACA MH/DS believes that all stakeholders are critical in creating and sustaining a viable community intellectual disability service system. All stakeholders bring a valued perspective and role in shaping the service delivery and administrative systems. Consequently, PACA MH/DS considers outreach to various stakeholders essential in an effort to create a model for future services.

Research basis:

National Council on Disability. *Analysis and Recommendations for the Implementation of Managed Care in Medicaid and Medicare Programs for People with Disabilities*. January 2012. http://www.ncd.gov/publications/2013/20130315/ cites stakeholder involvement with designing and operating a managed care system (principle 5)
Overview attached

Developmental discussion:

How can all stakeholders participate in development? When competing interests collide, what approach will be used to reach resolution?

Values

Pennsylvania is historically steeped in consumer focused values galvanized in 1991 with the adoption of *Everyday Lives.* In addition to these values, PACA MH/DS urges consideration of systemic values such as:

- Uniform statewide standards and outcomes
- Viable assessment process to identify individual and systemic development
- Reinvestment of savings into the community system
- Employment first

Self-Determination

Self-determination is crucial and continues to be an underpinning in the ever changing and adapting services. A broad definition of self-determination commonly accepted includes:

- Freedom to choose how to live life, including supports and services
- Authority over available resources, both public and private
- Support to organize resources in a purposeful manner to enhance the individual
- Responsibility to prudently use public dollars and recognize contributions individuals can make to the community
- Confirmation of the importance of the individual in creating a viable community member

Developmental discussion:

How will the system design reflect values? How to balance system standards and outcomes with individual standards and outcomes? What is the best use of the limited public funds supporting individuals? What values are most important to stakeholders? How much personal risk can the service system permit?

Eligibility

Federal standards require states to determine the following during the admission process:

- A diagnosis of intellectual disability or related condition
- The level of services provided by an Intermediate Care Facility for Individuals with Intellectual Disability(ICF/ID) with annual redetermination after admission

Research basis:

Section 1915(c) of the Social Security Act

Developmental discussion:

Is the current approach meeting the federal standards? Are there any options for consideration from stakeholders?

Administration - Intake, Eligibility and Enrollment

Counties are responsible for intake and determining eligibility for intellectual disability services. In the context of a managed care system for waivers, eligibility is much more specific; documentation of intellectual disability requiring ICF/ID level of care, Medical Assistance eligibility and available waiver capacity (as determined by the state) are prerequisites of enrollment in a managed care waiver.

County programs, directly or via contract, would have the following responsibilities:

- Initial demographic/diagnostic intake
- Initial Supports Coordination Organization options
- Prioritization of Urgency of Need
- Documentation regarding ICF/ID level of care – right to appeal
- Referral to County Assistance Office as appropriate
- County/state funded services as available and appropriate
- Capacity management coordination with state office
- Selection of individuals to enter waiver
- Request for assessments (i.e. Supports Intensity Scale) for individuals waiting for services, entering waiver and experiencing changing need

Managed Care Organization would have the following responsibilities:

- Individual rights notification
- Notification of choice
    - Self-directed services
    - Providers

State office would have the following responsibilities:

- Setting state standards for waiver eligibility and enrollment
- Capacity management of waiver
- Assessment (i.e. Supports Intensity Scale) administration

Research Basis:

Pennsylvania Mental Health/Intellectual Disability Act of 1966 defines Intellectual Disability
Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 1

Developmental discussion:

The current Priority of Urgency of Needs does not accurately or consistently inform the waiver enrollment process. What should the selection for enrollment process be? Can a standard review be developed to meet a fair witness process? Who should do the selection for enrollment process and determination? What controls and balances can be created to dovetail all processes?

Assessment

An assessment is an organized approach to identify gaps between what exists and what is desired. It is the first step in a planning process when resources can be directed to improve on the current situation.

A universal assessment is one applied uniformly across a population, which is the basis for identifying strengths to build upon and needs to minimize. A universal assessment tool, such as the Supports Intensity Scale (SIS), permits individual and systemic planning. An individual may identify a specific need in their assessment, while collective assessments can identify areas for service development.

The SIS is being applied in over half the states to identify levels of services and supports and allocation public dollars. This approach reinforces self-determination.

Research Basis:

Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Waiver Assurance 2
Attached overview - Assessments

Developmental discussion:

How do we create a more engaging process than the one that currently exists for families, self-advocates and supports coordinators? How do we create viable use for an assessment? Can the assessment identify a benefit package (i.e. budget ranges

and/or service packages) for individuals? Can the assessment measure individual and systemic outcomes?

Individual Planning

Home and Community-Based Services waivers require Person Centered Planning. Person centered planning follows these universal guidelines:

- The individual is the focus and locus of control for decision making throughout the process from when, where and who will participate on the team to the selection of service and support providers.
- The team explores informal and formal options for consideration of the individual to address expressed need.
- Individuals who need assistance in participation do not forfeit their participation in the team planning process.

Research basis: Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Waiver Assurance 2

Developmental discussion:

Do current practices reflect this approach? Are there areas to streamline the process or documentation? Do all individuals require the same intensity in planning? Do all individuals require supports coordination for planning? Is this a service or an administrative function?

Services

PACA MH/DS has yet to review or address service definitions. One benefit realized in HealthChoices was the creation of supplemental services. Supplemental services are services that are not contractually required and are funded from systems "savings." This approach has created evidenced based practices, increased informal supports, increased access to housing and more to benefit individuals with behavioral health needs in the community. The potential development could also exist in community intellectual disability services.

In addition, HealthChoices has been able to provide performance incentives to promote community capacity, which may be an option in the future for intellectual disability services.

Developmental discussion:

What service definitions are needed to meet ICF/ID level of care? How discrete and specific do service definitions need to be to address health, safety and welfare? How do we define active treatment? What constitutes "medical necessity" or "active treatment"? What type of services can be provided to families and care givers to promote the health and independence of individuals?

Care Management/Case Management

Care management and case management function to assure individuals receive appropriate services. Generally, care management is an administrative/clinical review and case management is individually focused. The approach varies by industry and population served. Both rely on assessments to identify needed services. In fact, numerous approaches are used for care and case management, which is a critical aspect for service delivery and administrative oversight capacity and worthy of consideration.

Various approaches and standards need consideration in determining the most effective approach to maximize resources and increase consumer choice and voice such as:

- Determine if Supports Coordination is a required service for all individuals
- Option to have a navigator/broker option for individuals who self-direct services
- Create a tiered approach to case management similar to mental health's Resource Coordination and Intensive Case Management
- Review findings of departmental study on case management

Regardless of the approach, the assessment and evaluation are critical initial steps in creating an individual plan. The Supports Intensity Scale in addition to other assessments would create a means to identify an appropriate benefit package for the level of care/need identified. An Individual Service Plan (ISP) would be developed identifying the choice of services and supports within the benefit package that corresponds to the assessed level of care. The ISP would then be reviewed to assure the services and supports assure the health, safety and promote independence.

Administrative Structure/Oversight

County programs, directly or via contract, would have the following responsibilities:

- Coordinate SIS administration
- Assure smooth transition into waiver, including continuity of service

Managed Care Organization would have the following responsibilities:

- Develop ISP directly or via contract with Supports Coordination Organization
- Identify appropriate benefit package for level of care based on assessed needed
- Authorize services to meet individual need for habilitation, health and safety
- Process ties to utilization management for individual outcomes that promote health and independence

Research basis:
Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 2

Critical Points

- The SIS is currently administered, but not used or incorporated into the care management process.
- The county serving as an MCO or the MCO overseen by the county would authorize or deny services.
- The Supports coordinator currently meets the federal standard for the Qualified Intellectual Disabilities Professional (formerly known as Qualified mental Retardation Professional), which is required in some level for plan development and review regardless of approach.
- Supports coordination is the role to develop the ISP.
- Individuals have varying degrees of ability and need for assistance to develop and execute their ISP.

Developmental discussion:

How do you address natural supports in care management? Should a systemic employment approach be part of the process? What would be the process if supports coordination is not an option for someone self-directing? What is the process for services needed that fall outside of the service package or authorized plan? What is the approach for individuals who opt out of services and supports?

<u>Administration - Provider Network</u>

Depending on the contractual arrangement, the county and the MCO would be responsible for the provider network for waiver services including:

- Negotiating rates with providers
- Licensing and credentialing of providers
- Meeting access standards
- Creating tailored services as driven by enrollee need
- Creating and implementing enrollment and disenrollment
- Providing provider incentives
- Creating sanctions
- Providing training and education
- Maintaining sufficient capacity

State office would have the following responsibilities:

- Identify state standards for facility based services
- Identify access standards
- License facility based services

Critical Points

- Whoever makes payment for services must be responsible for the provider network and rates.
- Phase-in of current providers will need to occur for a stable transition.

- Insurance law requires panel review and the ability to profile and monitor providers.

Research Basis:

Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 3
Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 5

Developmental discussion:

What are the required federal standards? What services/providers are affected by other state laws? Should there be more credentialing of individuals who provide supports?

Administration – Claims

Typically the managed care organization has sufficient information technology for verification of authorization and claims payment. The managed care organization would submit necessary data to the state system. All administrative structures would be responsible for reporting any fraud, waste and/or abuse.

Research Basis:
Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 5

Developmental discussion:

What role does HCSIS play in the future as the MCO typically pays claims?
Is it possible for the MCO to submit data as done with behavioral health managed care?

Administration – Planning

Counties do planning, which should dovetail with waiver planning to maximize resources. The state plans and creates policies to guide local planning processes.

Developmental discussion:

What tools and approaches should be incorporated into the planning process for service improvement and addressing individuals on the waiting list? Who or how are priorities for planning identified?

Administration – Quality Management/Quality Assurance

Quality assurance activities are numerous in order to maintain the integrity and viability of all aspects of the plan. These responsibilities would be identified as a county or managed care organization function to form a system of checks and balances to meet contract and waiver standards:

- Provider reviews
- FWA oversight
- Record audits
- Chart review – on site and audit
- MA eligibility verification
- Credential/license verification
- Incident management review for improvement
- Complaint review for improvement
- Establishing provider profiles
- Approach for creating preferred providers
- Consumer Satisfaction
- Create provider benchmarks and report cards

Research basis:
Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 4
Pennsylvania has in place IM4Q for National Core Indicators and Consumer/Family Satisfaction Teams for the Recovery-Oriented Systems Indicators, which both measure consumer satisfaction and outcomes

<u>Administration – Member Services</u>

MCO's member services typically provide enrollees support in regards to services. Some managed care organizations provide a 24/7 hot or warm line to assist with emergencies. General information and referral services are available.

Developmental discussion:

How does the knowledge and resources of the Health Care Quality Units become part of the new system? Is there a way to add value by linking crisis services with member services? Will this become a viable means to explore options outside the individual planning process? Are there member services families and consumers would want to include? Would individuals or their families like to have support groups or training opportunities?

<u>Administration – Fiscal Foundation</u>

Counties have experience with capitated contracts, which is a managed care financing approach. "Capitation" is the term used to describe a model for funding services. In capitated State funding, the State contracts to pay a "primary contractor" a mutually agreed upon monthly payment to fund an agreed upon list of services for each individual "covered". In the capitated model, the primary

contractor must provide the full amount of services needed to cover individuals, regardless of if the total cost is more or less than the total dollars provided. (A "primary contractor" is the County or entity accepting the total annual capitated payments. A "covered" individual is a State resident that is determined to be eligible for the services.)

In a simple capitated system, the number of covered individuals, multiplied by the number of months and the monthly payment defines the total annual dollars. For example, if there were 1000 individuals and a "capitated payment" of $200.00 per individual, per month the program would have one million two hundred thousand to cover a year's worth of services for 1000 individuals. There are also capitation models based on individual caps or with case rates.

In a capitated program, the payments are set based upon historic spending with factors such as cost of living and other changes factored in. Certified Independent Actuaries are used by both the State and the primary contractor to arrive at the most accurate "capitated payment" possible.

Critical Point:

Counties have directed reinvestment funds to create new services, improve current services and create new approaches in behavioral health. Currently there is no means to positively influence where any savings or profits are directed. Since governmental agencies may not have a profit, any proceeds must be returned to the state or be reinvested in the service delivery system.

Research Basis:

Title 42 Code of Federal Regulations 435.1010; 42 CFR 441.302 – State Assurance 5

Developmental discussion:

Who will hold the risk for the capitated contract? Will any savings or profit be reinvested in community services or will they default to an entity? Does an individual budget become an individual case rate? If there is profit sustained over time, can funds be used to address individuals waiting for services? Is there a critical number of individuals to cover a pooled risk? Are there demographic considerations for risk pools in this diverse state?

<u>Administration – Information Technology</u>

Currently the behavioral health managed care entities must provide data regarding claims to the state while intellectual disability services rely on HCSIS. PACA MH/DS has not explored options in this area.

Developmental discussion:

What is the best use of HCSIS? What can be included in the new administrative approach that would be more effective and efficient? What options are feasible?

Administration - Complaints and Grievances (additional option to fair hearing and appeal process)

Complaints and grievances are available to enrollees prior to fair hearing. Fair hearing is a required process. In addition, behavioral health managed care has created standards for a panel review with objective participants, which includes consumers permitting an alternative means to address concerns.

Developmental discussion:

What approach best works for individuals and families in stating complaints and grievances? How do complaints and grievances inform planning and development? What is the best approach to complaints and grievances to individuals with intellectual disability?

Resources

http://www.ncd.gov/publications/2012/Feb272012/; Guiding Principles: Successfully Enrolling People with Disabilities in Managed Care Plans http://hcbsassurances.org/assurancesataglance.html; Wavier Assurances at a Glance http://www.dpw.state.pa.us/cs/groups/webcontent/documents/manual/p_003130.pdf; HealthChoices Behavioral Health Program – Program Standards and Requirements – Primary Contractor http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/p_004161.pdf; HealthChoices Behavioral Health Programs – Appendices

PACA MH/DS

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Local Accountability for Managed Medicaid Services

CCAP and PACA MH/DS support county right of first opportunity for both mental health and intellectual disability services. The right of first opportunity means that county programs would be the first entity given the option to oversee care contracts with managed care organizations for community services. Counties can do this individually or by joining together, and would also have the option to default to a state contract.

The scope of the county proposal for managed care, which is increasingly used nationally, includes individuals currently served under the two federally funded Medicaid waivers for intellectual disability community services, the Consolidated and Person and Family Directed Supports waivers. Base funds are not included in this proposal, but county right of first opportunity allows better coordination of waiver and base funds at the local level and more flexibility to address the needs of individuals in the local community.

Under this proposal, counties would directly or contractually oversee a capitated pool to provide community intellectual disability services as is the case for behavioral HealthChoices, the current Medicaid managed care program for mental health and drug and alcohol services. The state and counties have never realized a loss from capitated contracts during the 10 years of operating the behavioral HealthChoices program. HealthChoices has met or exceeded all of its goals related to access, quality and stabilizing Medical Assistance spending.

The county oversight of a capitated pool for community intellectual disability services would still require the provision of state defined services for individuals receiving services in the Medicaid waivers. The state maintains oversight of all standards for the administration and service delivery with administrative operations being provided by a single county or group of counties.

GOALS

- Use the standardized statewide assessment already in place (Supports Intensity Scale, or SIS) to drive decisions about the level of care an individual receives
- Manage the system to focus on improving an individual's ability to live an everyday life in the community with services that meet their needs
- Leverage budgetary savings to serve individuals currently on the waiting list, improve existing services and close state centers
- Provide local oversight, access and accountability using the existing administrative structures of behavioral HealthChoices
- Improve coordination of care for individuals dually diagnosed with mental health and intellectual disability

STATE BENEFITS

- Program standards and quality incentives to be developed will focus on habilitation and helping individuals with an intellectual disability achieve their full potential in community settings.
- Streamline state operations with administrative structures being local, and in many cases, regionalized at the local level.
- County right of first opportunity allows local management to be more responsive to the needs of constituents and address emergency cases quickly. It also allows counties to work directly with providers to resolve emergency issues related to their fiscal viability.
- Provider rates can reflect the local marketplace and quality incentives can be developed to reward providers who support system changes.
- A fair allocation of resources based on assessed needs and managing with a focus on habilitation will result in savings that can be used to reduce the waiting list and move individuals currently residing in state centers to the community.

- Assessments –
A National Snapshot in Planning for Intellectual Disability Services

States with Universal Assessment (*Black and Leitch*)

Twenty two (22) states indicate they use a universal assessment tool for long-term care. Most national assessment tools are population specific (such as the Supports Intensity Scale for individuals with intellectual disability), while other tools can be applied across populations. Numerous states are developing their own universal (statewide) assessment tool to bridge across a variety of populations.

National Uniform Assessment Tools *(Black and Leitch)*

The approach to a statewide uniform assessment tool varies. Although some states develop their own assessment tool, the following is a list of current national uniform assessment tools.

Minimum Data Set (MDS)
The MDS is a Centers for Medicare and Medicaid Services (CMS) mandated assessment of all residents in Medicare or Medicaid certified nursing homes, assessing each individual's functional capabilities, and helping nursing home staff to identify health problems.

Minimum Data Set-Home Care (MDS-HC): The MDS-HC is a validated assessment tool created by interRAI Corporation that was modeled after the MDS. It was developed to assist agencies in identifying the needs, preferences, and strengths of elderly clients living in the community, although it may also be used for adults with disabilities. Several states are using this instrument for HCBS services.

Inventory for Client and Agency Planning (ICAP): The ICAP is a standardized assessment instrument that measures adaptive and maladaptive behavior. It can be used for both children and adults.

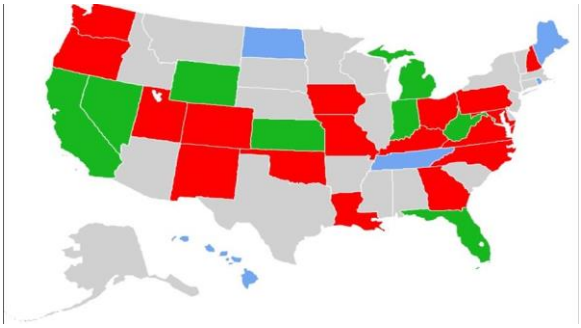
Continuity Assessment Record and Evaluation (CARE): The CARE Tool was designed for implementation with Medicare populations, primarily those who are aging and /or have physical disabilities. It was developed for use in acute and post-acute-care (PAC) settings participating in the PAC Payment Reform Demonstration.

Outcome and Assessment Information Set (OASIS): The OASIS tool collects data that can be gathered across home health agencies in a standardized manner, to improve the quality of services using outcomes-based quality improvement methods.

Supports Intensity Scale (SIS) - The SIS is a validated and normed tool developed by the American Association on Intellectual and Developmental Disabilities. The tool is designed for use with adults (16 and over) with developmental disabilities.

SIS Implementation

The SIS was published in 2004 by the American Association on Intellectual and Developmental Disabilities to measure support requirements in 85 daily living, medical and behavioral areas. The SIS is becoming a critical tool in budgeting through either provider or individual allocation processes. *The SIS does not create a level of care criteria as needed for ICF eligibility, a waiver requirement.*



Red is SIS implementation
Green is for SIS implementation as allocation process.
Blue is planning to move to SIS for allocation process.
http://aaidd.org/sis/sisonline/states-using-sis

Uses SIS for Allocation

Colorado*
Georgia*
Louisiana*
New Hampshire
New Mexico – 2013 full implementation – SIS done every three years
North Carolina* - for physical and behavioral health
Oregon*
Rhode Island
Utah
Washington*

*States using SIS to set individualized budgets

Planning for SIS Allocation Use

Kentucky*
Maryland*
Maine* – 2013 implementation target
Missouri*
New Hampshire*
New Mexico*

North Carolina*
North Dakota*
Pennsylvania*
Rhode Island*
Utah*
Virginia*

HSRI gap analysis occurring in Illinois, Texas, Florida (HSRI)for SIS allocation potential.

States considering assessment measures to set individualized budgets

Arizona
Connecticut
D.C.
Florida
Indiana
Mississippi
New Jersey
New York
South Dakota
Wyoming (DOORS implemented in 1998)

SIS Assessment Application for Allocation (*AAIDD White Papers)*

Applying the SIS for allocation purposes is an interactive process between two facets: prospective budget and service payments. Sound budgeting approach for individual services requires sound provider rates and vice versa. Consequently, when the SIS is used for allocation purposes, both facets are a consideration in creating a viable approach.

Prospective Budget

SIS is used to assign prospective budget amount or service level (an allocation) to an individual commensurate to individuals with similar needs

Service Payments

SIS is used to allocate a standardized provider rates for discrete type of service.

Internet Resources

Discussion of Key Resource Allocation Policy Issues in Louisiana, January 17, 2008 from http://www.nasddds.org/pdf/LouisianaPolicyIssues-FinalJanuary-17-2008.pdf

HCBS Community Living Clearinghouse Exchange Collaboration from http://www.communitylivingta.info/

Improving Home and Community Based Services Waiver Resource Allocation: Cross State Examination of Efforts to Develop Reimbursement Levels and Individual Budgets Using the Support Intensity Scale at the 24th National Home and Community Based Services Conference, Boston MA October 1, 2008 from http://www.nasua.org/hcbs_conference/hcbs_08.html

Level Building Models for DD Waiver-SIS Assessment Based Reimbursement SIS Leadership Forum, Washington DC May 27, 2008 from www.hsri.org/docs/SIS_Reimbursement.PPT

National Core Indicators from http://www.hsri.org/nci/

Person-Centered Planning and Individual Budgeting Audio Conference – 10-12-2004 and presentations by Wyoming and New Hampshire from http://www.hcbs.org/moreInfo.php/nb/doc/977

Sustainable Care Presentation by HSRI Val Bradley from http://www.hsri.org/docs/sustainfuture_OC.ppt

Use of the SIS in evaluation of costs of services for persons with disabilities: experience in theUSA, November 12, 2008 from www.anffas.net/download.asp/file=J_**FORTUNE**.pdf

Virginia Tools of Transformation Supports Intensity Scale, DMHRSASA 2008 from http://www.dmhmrsas.virginia.gov/OMR-SIS.htm

Waiting Lists and Olmstead: Promising Practices: Standard 2 Virginia utilizes the Supports Intensity Scale by Tony Records, TRA Inc. Reinventing Quality Conference, Baltimore, MD, August 10, 2008 from http://www.reinventingquality.org/docs/Tonyrecords-08.pdf

Wyoming Individual Budget Methodology, a CMS promising practice – 12-18-2007 from
http://hcbs.org/files/67/3331/Wyoming--IndividualBudgetsupdate.pdf
http://www.hsri.org/files/uploads/news/Sustainable_Futures_-_AAIDD_2012.pdf