DHHS STATUS REPORTS
BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING RECOMMENDATIONS
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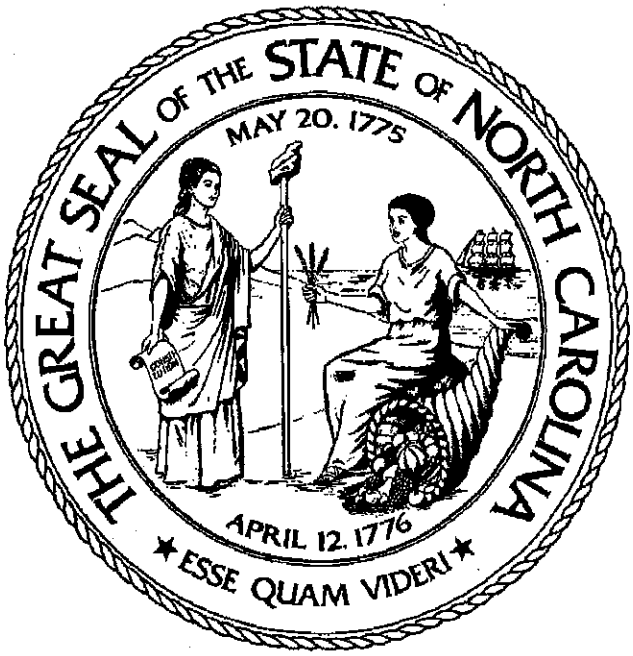

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

March 2013

SUMMARY

This report will provide Department of Health and Human Services (DHHS) status updates on recommendations 2, 8, and 9 from the Subcommittee on Adult Care Homes of the Blue Ribbon Commission on Transitions to Community Living, and Recommendation 7 from the Subcommittee on Housing.

SUBCOMMITEE ON ADULT CARE HOMES RECOMMENDATION 2: MITIGATE THE LOSS OF MEDICAID ELIGIBILITY BY THOSE EXITING AN ADULT CARE HOME

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State-County Special Assistance as an adult care home resident for this specific population for a set period of time. The Department must explore, but is not limited to, the following options: the implications of tying the receipt of SA In-Home to Medicaid eligibility as is the current practice for SA-ACH recipients; acquiring a federal disregard for residents moving from a facility to a home to allow a waiver of their deductible; and investigating the Medicaid Health Insurance Premium Payment Program provision to determine whether Medicaid can pay the "premium" for these individuals so they remain Medicaid eligible. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

State-County Special Assistance for Adults (SA) provides a cash supplement to help low-income individuals residing in adult care homes (such as rest homes) pay for their care. Adult care homes (ACHs) are unlike nursing homes in that medical care is not provided by home staff. Designated staff may administer medications and provide personal care services such as assistance with bathing, eating, and dressing. ACH residents with diagnosed with Alzheimer's or a related disorder may reside within a licensed Special Care Unit (SCU) in an ACH.

The State/County Special Assistance In-Home Program for Adults (SA/IH) provides cash supplements to help low-income individuals who are at risk of entering a residential facility such as an ACH or supervised living group home, and would like to remain at home. SA/IH provides an alternative to placement in this type of residential setting for individuals who could live at home safely with additional support services and income. However, unlike the SA program for residents of ACHs (SA-ACH), individuals must be determined eligible for Medicaid in the Aged, Blind, and Disabled Medicaid (ABD) program categories before being evaluated for an SA/IH payment. This means that to be eligible for the SA/IH payment an individual first must have income that does not exceed the Medicaid income limit for the ABD population of 100 percent of the federal poverty level (FPL). Individuals currently eligible for SA-ACH may have a higher income level than 100 percent FPL.

Implications of tying the receipt of Special Assistance In-Home to Medicaid eligibility, as is the current practice for SA-ACH

It is possible to set aside a fixed percentage of income so that it is not considered when determining eligibility, also known as an income disregard. Medicaid income disregards for the aged, blind, and disabled are governed by the Supplemental Security Income (SSI) program, as required under 42 C.F.R. 435.601(a). By using an income methodology that is "less restrictive" than SSI, the Medicaid program can apply an income disregard to raise the Medicaid income limit to the SA/IH payment eligibility amount. However, as required under 42 C.F.R. 435.602(d)(2), such a disregard would have to apply to ALL Medicaid aged, blind, and disabled eligibility groups and would result in an expanded ABD population.

Currently, the income limit for ABD is 100 percent of the federal poverty level (FPL). Any disregard would raise the income limit for all individuals in those programs. The SA-ACH income threshold is higher than the ABD income limit, at 132 percent FPL, or $1,228 per month. To equalize the SA/IH income limit to the SA-ACH limit would require a disregard of $297 to bring the maximum income allowed under the 100 percent FPL limit of $931 for an individual. Such an income disregard would have to apply to all ABD beneficiaries living in the community, not only to SA/IH beneficiaries, and would result in more individuals becoming eligible for Medicaid.

Alternatively, the increased income limit could be limited to the income threshold for the SA program for individuals residing in Special Care Units (SCUs), which is $1,561 per month (approximately 168 percent of FPL). Individuals may exit to the community from the SCU and will need the protection of the disregard. To equalize the SA/IH income limit to the SA-SCU limit would require a disregard of $630 to bring the maximum income allowed under the 100 percent FPL limit of $931 for an individual. However, under 42 C.F.R. 435.602 a disregard must apply to all in the eligibility group, in this case everyone in the ACH, not just those residing in SCUs.

It is difficult to determine the number of individuals who would potentially become eligible for the SA/IH program under either of these options, as these populations are not currently enrolled in Medicaid. However, it would represent an expansion of Medicaid to a traditionally high-cost population.

Any disregard would require submission of a State Plan Amendment (SPA) along with the fiscal impact and funding source to CMS, development of Administrative Procedures Act rules, revisions to the SA and ABD program manuals, as well as programming eligibility rules changes in NCFAST. Because of implementation deadlines for NCFAST, new program rules cannot be accommodated at this time. Completion of these tasks and training of eligibility workers at the county departments of social services would normally be a 6 to 8 month process. However, the programming changes required in NCFAST could not be accomplished until 2014 at the earliest.

Changing Special Assistance (SA) In-Home Program into part of the State/County Special Assistance Program

As a State statutory program, SA/IH has limits on the number of individuals who are eligible for the program. These limits may be increased or decreased by legislation. Incorporating SA/IH into the Special/County Special Assistance Program, which would be allowed in 42 C.F.R. 435.232, would make eligibility an entitlement without limits on the number of potential enrollees. Eligibility for Medicaid would be based on the receipt of an SA payment rather than policy of the ABD programs, therefore potentially increasing the number of individuals receiving Medicaid at higher incomes. However, as part of the federally-defined SA program, the higher income limit, or a corresponding income disregard, need not be applied to all ABD beneficiaries, just those receiving SA either in homes or in ACHs or SCUs.

SUBCOMMITTEE ON ADULT CARE HOMES RECOMMENDATION 8: EXPLORE SERVICE DELIVERY OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS

The Blue Ribbon Commission on Transitions to Community Living directed the Department of Health and Human Services to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) review of State Plan services and making clinical and rate recommendations to amend the 1915 (b) waiver upon approval of the NC General Assembly. The Department shall present findings, anticipated costs, and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Service, on or before March 1, 2013.

This recommendation dovetails with the following Blue Ribbon Commission Recommendation:

SUBCOMMITTEE ON HOUSING RECOMMENDATION 7

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct DHHS and the LMEs/MCOs to determine the additional services and resources needed to support the transition of 3,000 mentally ill persons from adult care homes to community-based settings by June 30, 2020. No later than March 1, 2013, DHHS shall submit a written report to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees and the House and Senate General Government Appropriations Subcommittees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

In response to the Blue Ribbon Commission recommendations, this report details findings of internal and external reviews of the North Carolina mental health service array, summarizes

existing mental health and substance abuse services, and presents recommendations for enhancement of the current Medicaid behavioral health services

Reviews of Current Mental Health and Substance Abuse Adult Service

DHHS divisions, paid external consultants, and consumer advocacy organizations have conducted numerous qualitative and quantitative gap analyses of the current North Carolina mental health service array. This report synthesizes the results from all available gap analyses in order to identify any need for expansion of Medicaid State Plan or 1915(b)(3) services.

1. **US Department of Justice letter to North Carolina**

In a letter dated July 28, 2011, the US Department of Justice (DOJ) concluded that:

> North Carolina failed to "...develop a sufficient quantity of community-based alternatives..." and "[t]he types of services needed to support people with mental illness in community-based settings already exist in North Carolina's community-based mental health service system. These services include ACT teams, Community Support Teams, case management services, peer support services, supported employment services, and crisis services..." ... "Given the array of services...providing services to people with mental illness can be reasonably accommodated."

The report went on to recommend that "the State should ensure that its quality management systems are sufficient to assure that all mental health services funded by the State are of good quality and are sufficient to help individuals achieve positive outcomes...".

2. **Analysis of Service Gaps in the Mental Health, Developmental Disabilities, and Substance Abuse Services (April 1, 2010)**

This report was in response to Session Law 2008-107, Section 10.15(f), which directed DHHS to perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System, involving local management entities (LMEs).

The report synthesized gap analyses and recommendations from consumers, LMEs, and other stakeholders. The report finds that long-term supports for independence and recovery are necessary but insufficient in North Carolina, leading to recommendations for the following:

- Safe and affordable housing
- Employment opportunities and supports
- Emergency respite
- Timely access to affordable medications
- Primary healthcare
- Transportation
- Post-secondary education opportunities
- Opportunities for recreation and community involvement

The report also noted that the following opportunities exist to enhance the mental health and substance abuse service quality and accountability:

- Consistent, high quality assessments and services
- Evidence-based practices
- Sharing of information through efficient data systems

3. Mercer Report

In 2012, Mercer Human Services Consulting (Mercer) performed an analysis of the behavioral health service array available to NC Medicaid beneficiaries. Mercer reviewed existing reports and Local Management Entity-Managed Care Organization (LME-MCO) service gap analyses. Mercer concluded that DHHS does offer a complete array of mental health and substance abuse services. However, these services need to be revised to require evidence-based practices. Mercer recommended that current services funded only through State dollars of Money Follows the Person (MFP) should be expanded as Medicaid 1915(b)(3) services available statewide. These services include Transition Year Supports, Peer Support, and Supported Employment.

4. Money Follows the Person (MFP) Demonstration: Overview of State Grantee Progress, July-December 2010 by Mathematic Policy Research, Inc. (May 2011)

A Mathematica Policy Research report reviewed North Carolina's Money Follows the Person transitional program that transitions individuals in institutional settings to a community-based living situation. It suggested that a lack of robust case management services destabilized the community support structure for individuals transitioning into community settings.

5. Trapped in a Fractured System: People with Mental Illness in Adult Care Homes, Special Report: Disability Rights North Carolina (August 2010)

Disability Rights North Carolina (DRNC) issued a special report due to concerns about adults with mental illness living in Adult Care Homes with little reported integration into the community. With respect to services, DRNC recommended that North Carolina develop long term care services and supports in the community for adults with severe and persistent mental illness (SPMI), including but not limited to the clubhouse model of day programming, personal care services, and peer support. The report also recommended development of a robust supported employment initiative for adults with mental illness.

Summary of Findings

- While a complete service array does exist, services are not focused on evidence-based practices which improve the chances of beneficial outcomes.
- Specialized case management protocols have not focused on the needs of individuals transitioning into community settings.

- The current statewide service array is restricted to rehabilitative services. Some supports, such as peer support, supported employment, and one-time transitional funds, are necessary to facilitate successful community living.

Current North Carolina Medicaid Mental Health Service Array for Adults

Eligible Medicaid beneficiaries may access a broad array of mental health services. These services include: Partial Hospitalization, Assertive Community Treatment (ACT), Community Support Team (CST), Psychosocial Rehabilitation (PSR), Facility-Based Crisis (FBC), Mobile Crisis Unit (MCU), Diagnostic Assessment, and Outpatient Therapy and Medication Management. Peer Support is also currently available as a State-funded service and as a 1915(b)(3) service through LME-MCOs. The following is a summary of these services.

Assertive Community Treatment (ACT)

ACT is a wrap-around, team approach to community-based mental health care for individuals with severe mental illness who might otherwise need hospitalization The ACT Team service is provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week, and is prepared to carry out a full range of treatment functions wherever and whenever needed. Structured, face-to-face scheduled therapeutic interventions provide rehabilitative support and guidance in the adaptive, communication, personal care, employment, domestic, psychosocial, and problem solving function domains. The service prevents, overcomes, or manages the beneficiary's level of functioning and enhances his/her ability to remain in the community. The ACT Team also addresses substance abuse, housing, medical needs, and employment issues. While ACT is considered an evidenced-based treatment, NC has no system for monitoring fidelity to the evidence-based practices.

Community Support Team (CST)

Community Support Team (CST) services consist of community-based mental health and substance abuse rehabilitation services and supports to assist adults in achieving rehabilitative and recovery goals. Individualized treatment by the team may include therapy, behavioral intervention, substance abuse treatment, relapse prevention strategies, psychoeducation, symptom self-management, intensive case management, and crisis management.

Psychosocial Rehabilitation (PSR)

PSR focuses on skill and resource development to increase the beneficiary's ability to live as independently as possible, to manage their illness and their life with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals. These interventions are focused on promoting recovery, symptom stability, increased coping skills and achievement of the highest level of functioning in the community.

Peer Support (PS)

Peer Support services (PS) is a community-based service for adults who have a mental illness or a substance abuse disorder, provided by a North Carolina Certified Peer Support Specialist. Peer support is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice.

Mobile Crisis Management (MCM)

Mobile Crisis Management involves all support, services, and treatments necessary to provide integrated crisis response, stabilization interventions, and prevention activities. Mobile Crisis Management services are available 24 hours a day, 7 days a week, 365 days a year. Crisis response provides an immediate evaluation, triage, and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports reduce symptoms or harm, and/or safely transition beneficiaries in acute crises to appropriate crisis stabilization and detoxification supports and services.

Facility-Based Crisis

Facility Based Crisis services provide an alternative to hospitalization for adults who have a mental illness or substance abuse disorder. Provided in a 24-hour residential facility with 16 beds or less, it provides support and crisis services in a community setting and can be provided in a non-hospital setting for recipients in crisis who need short-term intensive evaluation, treatment intervention, or behavioral management to stabilize acute or crisis situations.

Recommendations for Medicaid State Plan and 1915 (b)(3) Services

In order to support individuals in community based settings, DHHS recommends the following additions or enhancements to the current mental health service array. It should be noted that any costs have been accounted for in SFY 2012 and subsequent budgets related to the US DOJ Settlement Agreement.

1. **Assertive Community Treatment (ACT):** Modify ACT policy by requiring fidelity to an evidence-based treatment model that includes employment and housing supports. ACT is an existing Medicaid State Plan service.
    - *Clinical Revision:* The ACT policy is in the process of being re-defined according to the Tool for Measurement of ACT (TMACT), an evidence-based ACT model that is expected to result in decreased hospital utilization, more independent living and housing stability, retention in treatment, and beneficiary satisfaction. ACT teams must be monitored to ensure fidelity to the TMACT model and, thus, ensure high quality and positive outcomes.
    - *Training and Fidelity Monitoring:* DHHS will contract with the UNC Center for Excellence in Community Mental Health ACT Technical Assistance Center (TAC) for development, implementation, and support for a long-term ACT program fidelity implementation plan. This will ensure that an adequate number of high fidelity ACT teams are available throughout the State. ACT TAC will be responsible for program evaluation, training, and consultation, as well as directly

evaluating ACT teams and supervising TMACT reports that are submitted by evaluators.

Proposed Year 1 Scope of Work:

- *Oversee ACT Program Fidelity Implementation and Quality Improvement Efforts in NC* (train fidelity evaluators, train ACT teams in TMACT model, conduct TMACT fidelity evaluations, supervise fidelity process to ensure reliable and valid ratings, provide ongoing education and training to stakeholders, including MCOs and providers, develop TA website)
- *Directly provide consultation and technical assistance to ACT teams* (provide initial, time-limited consultation to ACT providers following TMACT evaluation to offer coaching and consultation).
- *Collaborate with ACT Stakeholders to Facilitate Best Practices* (consult with DMHDDSAS and DMA on ACT policy and assist with outcome tracking)

Cost Implications: The five-year DOJ Settlement budget includes costs for fidelity training and monitoring as well as rate increases to support the new service requirements.

	SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16	SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20
Training & Fidelity	$66,863	$62,500	$62,500	$62,500	$62,500	$62,500	$62,500	$62,500
Increased Rates	$799, 155	$1,718,245	$1,847,101	$1,985,374	$2,134,549	$2,294,628	$2,478,000	$2,478,000

2. **Supported Employment (SE):** Initially, SE will be developed as a State-funded service, and then transition to a Medicaid-funded 1915(b)(3) service by January 2014. SE offers real-time supports focused on obtaining and maintaining long-term, competitive employment for individuals in recovery from mental illness and substance abuse. The service definition should specify an evidence-based model that involves measured outcomes.
    - *Clinical Revisions:* The previous SE policy has been revised to be consistent with evidence-based models of supported employment and ensure improved quality.
    - *Training:* Contract with NC Employment First Technical Assistance Center to develop training, build provider capacity, and educate stakeholders and target audiences. The TAC will develop and deploy training plans and help the state and LME-MCOs build provider capacity. Evaluation and outcome data will be gathered and used to inform future trainings.
    - *Cost:* As a (b)(3) service, the cost of SE is offset by savings realized under the 1915(b)(c) waiver. SE is currently State-funded, but will be implemented as a Medicaid service in the next year

Cost Implications: The DOJ budget includes funding Supported Employment technical assistance and training through SFY 14-15 ($46,508 through July 2013, then $90,000 for

each of SFY 13-14 and SFY 14-15). As of January 2014, SE will also be a 1915 (b)(3) services funded through savings realized by the LME-MCO waivers.

It is not yet clear whether more Technical Assistance funding will be needed after the initial start-up year to continue with training and fidelity monitoring. The evidence-based practices for SE are still being reviewed and the service definition is still under revision.

3. **Transition Year Stability Funds:** Following Money Follows the Person, one-time transition funds of $2,000 were made available to high priority individuals transitioning to independent living. This cost is included in the DOJ Settlement budget.

4. **Peer Support (PS):** PS is currently a 1915(b)(3) service as well as a State-funded. PS involves the use of trained individuals who have experienced mental health and substance abuse issues to aid in recovery from mental illness and substance abuse. PS provides individuals with a validating community that builds interdependence and mutual responsibility. *Clinical Revision:* PS is currently being revised with attention to evidence-based models of practice.

   Cost Implications: Peer Support Services PSS will also be a 1915 (b)(3) services funded through savings realized by the LME-MCO waivers, requiring no additional service dollar allocation.

   Some Technical Assistance funding will likely be needed to help with training and fidelity monitoring. However, the service definition is currently under revision and promising practices/evidence is being reviewed to determine the best model of Peer Support for our consumers.

5. **Personal Care/Individual Support:** This is a proposed service currently only available in the Cardinal Innovations catchment area. Personal Care (Individual Support) is a "hands-on" service for persons with severe and persistent mental illness (SPMI). The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living (IADLs), such as preparing meals, managing medicines, grocery shopping and managing money, so they can live independently in the community. The supports will include skills training, social skills training to develop positive relationships and stronger support networks, communication, self-advocacy, informed choice, community integration, pre-employment readiness, recovery education, and change readiness. The individual need for the service is expected to "fade" or decrease over time as the individual becomes capable of performing some of these activities more independently.

   At this time, Personal Care/Individual Support is considered a 'pilot' service. This 1915 (b)(3) service could be expanded to the other LME-MCOs over time upon realizing any additional savings under the waivers.

SUBCOMMITTEE ON ADULT CARE HOMES RECOMMENDATION 9: CAP-IDD (INNOVATIONS) MEDICAID WAIVER SLOTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to expand the number of available CAP-IDD (Innovations) Medicaid Waiver slots within current funding and to unfreeze current slots within current funding constraints. The Department shall report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

The Division of Medical Assistance (DMA) operates a 1915(c) waiver for individuals with intellectual and developmental disabilities. The 1915(c) waiver allows individuals to live in community settings with services and supports instead of receiving care in institutional settings. Historically, the waiver was called the Community Alternatives Program (CAP) waiver. The waiver is now called the "NC Innovations" waiver. In SFY 2013, DMA created 250 new 1915(c) waiver slots and an estimated 500 current slots were unfrozen. DMA currently funds 12,448 slots.

In order to distribute these slots to new beneficiaries, DMA submitted a Technical Amendment (TA) to the NC Innovations waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. CMS approved the TA on December 10, 2012.

DMA worked with Mercer Human Services Consulting (Mercer) to develop an allocation method for distribution of the slots based on the historical slot allocation process for the CAP waiver. Slots are allocated to LME-MCOs who distribute them to individuals on their wavier wait lists. Mercer allocated the slots to LME-MCOs on a per capita basis.

DMA distributed slot allocation letters to the LME-MCOs on January 14, 2013 and held a technical assistance call to answer any questions. A Special Medicaid Bulletin was published in January 2013 informing providers and beneficiaries that slots were distributed to the LME-MCOs.