Long - Term Supplemental Assistance

For

Group Homes

Session Law 2014 - 100

Sections12A.7. (a) – (h)

April 1, 2015

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

LONG-TERM SUPPLEMENTAL ASSISTANCE FOR GROUP HOMES

APRIL 1, 2015

BACKGROUND

Legislative

Session Law 2014 – 100, Sections 12A.7. (a) – (h) appropriated to the Department of Health and Human Services, Division of Central Management and Support, the sum of two million dollars ($2,000,000) in nonrecurring funds to be used to provide temporary, short-term financial assistance in the form of a monthly payment to group homes on behalf of each resident who meets all of the criteria stated in Section12A.7. (a & b) of the law. The requirements of this law were implemented in September 2014 via allocation letters issued by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), Financial Operations Office to the Directors of each Local Management Entity – Managed Care Organization (LME/MCO).

Section 12A.7. (e) of this law requires that: ***"****By no later than April 1, 2015, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division: (1) A plan for a long-term solution for individuals residing in group homes who would like to continue residing in this setting and, as a result of an independent assessment, have been determined to need only supervision, medication management, or both."*

Group Home History

The .5600(a) and .5600(c) licensed group homes provide a critical residential option for many individuals with mental health (MH) and/or intellectual and developmental disabilities (IDD) across the state of North Carolina. These homes continue to be a part of the continuum of service for people with disabilities in NC.

In the 1990s, the North Carolina General Assembly approved the then NC Department of Human Resources (DHR) legislative proposal that separated the personal care services costs from the room and board costs and allowed DHR to submit a state plan amendment allowing group homes and adult care homes to bill personal care services for individuals residing in the homes. At the same time, rates for Special Assistance (SA) were reduced for these programs.

Over the past 20 years, funding sources have continued to shift, and .5600 licensure rules have remained virtually unchanged. This has resulted in an antiquated system with a patchwork of funding streams that do not accurately reflect the true needs of individuals or the costs to support them. While this funding reality significantly impacts both .5600(a) and .5600(c) group homes, group home expenses vary slightly by size of group homes. Any revenue decrease and/or the economic impact of providing services below capacity disproportionately impacts smaller group homes. The 5600(a) homes

experience higher costs associated with occupancy rates and maintenance- related staff time, building maintenance, and furnishings replacement. Further, it is anticipated that the implementation of the federally required Home and Community Based Services (HCBS) Rule changes along with changes through the employer mandate of the Affordable Care Act could further increase the costs for food, transportation, staff and training.

Our system is further complicated by the lack of uniformity of supplemental funding for support services inside the group homes. Some homes receive additional funding through contracts with LME/MCOs through either state appropriated funds or Innovations Waiver funds (which are only available for people with IDD). All of the homes are monitored by the Division of Health Service Regulation (DHSR) in accordance with state licensure rules. Additionally, the LME/MCOs monitor those group homes with which they have a contract. The Division of Medical Assistance is responsible for monitoring individuals who receive Personal Care Service. DHSR does performs complaint resolution, annual reviews and inspections of each group home, which can result in license suspensions and revocations in egregious situations. The licensure rules require that these homes shall maintain a client ratio of at least one staff ratio per six individuals to enable staff to respond to individualized client needs. While the rule allows for flexible staffing above the minimum required, without an LME/MCO contract there is no funding stream to pay for the additional staffing when needed for a particular client. This may result in group homes choosing to serve individuals with less severe needs to avoid being out of compliance with Center for Medicaid and Medicare Services (CMS) and state licensure rules while continuing to serve the needs of the residents. The reduction of Personal Care Service (PCS) funding for individuals with MH and IDD in small group home settings has narrowed further the financial margin for many group home providers.

The following profiles provide a picture of the client populations that depend on this residential service.

Profile 1 – Between 2001 and 2012, an individual with schizophrenia had 19 hospital admissions, a trend of 1.72 hospitalizations per year. He had four suicide attempts. He moved to a group home in January 2012, and has had no hospital admissions in 36 months.

Profile 2 – Between 1995 and 2006, 400 days were spent in the hospital by this individual. He had 25 hospitalizations in eleven years, a trend of 2.25 hospitalizations per year. He moved into a group home in 2006; He has had three hospitalizations in the nine years he has lived in the group home, a trend that reduced average hospitalizations by almost two per year.

Profile 3 – A 32 year old man who has lived in a group home for the past nine years. He lives with five other individuals in a residence which, until

recently, was supervised by one direct support professional. During the day, he participates in a day program. He utilizes the services of NC START monthly. His family consists of his mother, who receives residential care in a different setting, and his aunt (and legal guardian), whom he visits on a regular basis. He is an engaging young man with a ready smile. He enjoys model cars and trucks and going on outings. This individual's diagnoses include low IQ, autism, attention deficit disorder (ADHD), intermittent explosive disorder, and impulsive control disorder. He reflects the increasing number of individuals with intellectual and developmental disabilities and a co-occurrence of behavioral health concerns. These diagnoses lead to challenging behaviors that require significant supervision, and at times intervention. Staffing has increased at his residence to ensure his safety as well as the safety of other residents.

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Profile 4 – A young man with autism and has been a resident of a group home for 18 Years. His parents are in their 80s with poor health. He has no other family. Without adequate and consistent funding he is at risk of losing his only residential option and entering a crisis system which is not prepared to support his long-term individual needs.

LONG TERM SOLUTION

Process

Per this requirement, the DHHS Director of DMH/DD/SAS and the DHHS Deputy Secretary for Behavioral Health and Developmental Disabilities, convened a stakeholders workgroup in October of 2014, to provide input into the DHHS development of potential long-term solution(s) for supplemental assistance for group homes with .5600(a) and .5600(c) licensure designations that house individuals identified in Section12A.7. (a)(1) & (2) of Session Law 2014-100. The workgroup included key DHHS staff from the Divisions of Aging and Adult Services, Medical Assistance, Health Service Regulation, and Mental Health, Developmental Disabilities and Substance Abuse Services; LME/MCOs; individual consumer advocates and key staff from NAMI North Carolina; and key staff from group home and individual providers and provider associations, including The Arc North Carolina, the North Carolina Developmental Facilities Association, Benchmarks, the NC Providers Council, the NC Providers Association, and the National Association of Social Workers NC Chapter.

In an effort to better identify a long- term solution to group home funding, the larger workgroup requested that those members who were group home providers and the members representing the provider advocacy organizations would form a subgroup to reach out to providers of .5600 (a) and (c) licensed group homes across the state to determine the estimated cost of "room and board" separate from rehabilitative or

habilitative service delivery. Specifically, the subgroup was asked to identify whether the Special Assistance (SA) and Supplemental Security Income (SSI) revenues were adequate funding streams to cover room and board costs for individuals living in .5600 (a) and (c) licensed group homes.

The work of this sub-group clearly indicated that for those providers who rely solely on the SA/SSI and PCS funding there is little available margin to pay for support services. With future inflationary cost, the group believes that many of these providers will have a difficult time sustaining operations without additional funding.

For those group homes that receive additional support from the LME/MCO, the ability to provide support services is greater. However, because they often support people with greater need, the loss of PCS funding for some residents can have a significant impact on operations and quality.

RECOMMENDATIONS

The stakeholder workgroup provided input into DHHS's development of these recommendations. However, the recommendations included in this report are the recommendations of DHHS.

Though the recommendations below will strengthen our group home system, there is no one recommendation that will guarantee the stability of all group home providers. Our system continues to evolve and new challenges and opportunities will be presented. These recommendations represent the best opportunity to stabilize the system while constantly reviewing options as we implement Medicaid reform.

The first two recommendations will require legislative approval to move forward. Although we cannot predict how quickly CMS would approve these changes we believe a reasonable timeline for the (b)(3) service changes is six months while developing and submitting the supports waiver would take 9-12 months. This will require DHHS to work with LME/MCOs to assure the viability of Group Homes during fiscal year 2015-16 until the changes in the Medicaid program are implemented.

1. Utilize the existing Personal Care/Individual Support Service, a 1915 (b)(3) service available as a result of the projected savings under the NC MEDICAID 1915(b) waiver. The 1915(b)(3) service does not create an entitlement and does not increase the budget requirements since it is funded by projected savings. The current service is written as follows:

> "Personal Care/Individual Support is a 'hands-on' service for persons with severe and persistent mental illness. The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living, such as preparing meals, managing medicines,

grocery shopping, and managing money so they can live independently in the community."

Because this service was designed only for individuals with a severe and persistent mental illness (SPMI) to live independently in the community, it is necessary to request approval from CMS to amend the service definition. The amendment would include adding individuals with SPMI living in .5600(a) group homes and individuals with IDD and not covered under the NC Innovations Waiver, living in the community independently or in .5600(c) group homes to the populations covered by this definition. In addition, any other changes found to be needed in order to ensure the effectiveness of the definition will be added to the amendment request. This change in service definition will not increase the budget requirements for the LME/MCO system.

2. Use a supports Waiver, as defined in the legislative report dated March 1, 2015, titled "Additional Medicaid 1915c Supports Waiver", to support individuals who are eligible for the waiver services with IDD in licensed group homes. The supports waiver will allow for individuals with IDD who need less intensive services to receive those through a Home and Community Based Waiver. DHHS is currently reviewing options to implement this waiver without increasing state funded appropriations.

3. Evaluate all individuals with IDD currently living in licensed group homes to determine if they are eligible for the Innovations Waiver. If they are not already on the waiting list for this waiver, this will assure that they are included.

4. Continue to meet with the stakeholder group and LME/MCOs to review additional opportunities for stabilizing the community group home service.

5. Evaluate the current policy that requires LME/MCO letters of support as a condition for adding additional licensed beds in group homes. Currently there is no requirement for an identified funding source beyond SA and SSI. To assure that future Group Homes will be stable, we must review and improve this process.

6. Work with LME/MCOs to identify individuals who have a mental illness and live in licensed group homes that do not have contracts with LME/MCOs. This work should determine if individuals are eligible for services available under the 1915(b) waiver.

7. Identify any additional Medicaid funding options that may be appropriate for individuals served in group homes, once a Medicaid Reform Plan is passed.

8. Report to the NC General Assembly any additional recommendations DHHS determines appropriate to support the residential continuum in February of 2016.

FUNDING SOURCES

Methodology for Disbursement of Bridge Funding

The principle criteria for eligibility revolved around the individual and the treatment received under the Medicaid State Plan and the length of time the individual had received services. This was an important distinction used in developing a list of clients, and their original Medicaid home county, that could potentially meet the eligibility criteria. This list was used to determine the original amount of bridge funding allocations for each LME/MCO in August 2013. The unused bridge funds of $2,000,000.00 from State Fiscal Year (SFY) 2014 were re-appropriated by the state legislature for use in SFY 2015. The same ratio of clients per LME/MCO used in SFY 2014 for determining the allocation amounts to each LME/MCO were used to distribute $2,000,000.00 for SFY 2015.

The following is the actual current legislation which details the client eligibility criteria and the monthly payment amount per client:

SECTION 12A.7.(a) *Notwithstanding any other provision of law, funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2014-2015 fiscal year for unpaid LME liabilities is reduced by the sum of two million dollars ($2,000,000) in nonrecurring funds, and that amount is instead allocated to the Department of Health and Human Services, Division of Central Management and Support, for the 2014-2015 fiscal year to provide temporary, short-term financial assistance in the form of a monthly payment to group homes on behalf of each resident who meets all of the following criteria:*
(1) Was eligible for Medicaid-covered personal care services (PCS) prior to January 1, 2013, but was determined to be ineligible for PCS on or after January 1, 2013, due to Medicaid State Plan changes in PCS eligibility criteria specified in Section 10.9F of S.L. 2012-142, as amended by Section 3.7 of S.L. 2012-145 and Section 70 of S.L. 2012-194.
(2) Has continuously resided in a group home since December 31, 2012.

SECTION 12A.7.(b) *These monthly payments shall be subject to all of the following requirements and limitations: (1) The amount of the monthly payments authorized by this section shall not exceed four hundred sixty-four dollars and thirty cents ($464.30) per month for each resident who meets all criteria specified in subsection (a) of this section. (2) A group home that receives the monthly payments authorized by this section shall not, under any circumstances, use these payments for any purpose other than providing, as necessary, supervision and medication management for a resident who meets all criteria specified in subsection (a) of this section. (3) The Department shall make monthly payments authorized by this section to a group home on behalf of each resident who meets all criteria specified in subsection (a) of this section only for the period commencing July 1, 2014, and ending June 30, 2015, or upon depletion of the two million dollars ($2,000,000) in nonrecurring funds appropriated in this act to the*

Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section, whichever is earlier. (4) The Department shall make monthly payments authorized by this section only to the extent sufficient funds are available from the two million dollars ($2,000,000) in nonrecurring funds appropriated in this act to the Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section. (5) The Department shall not make monthly payments authorized by this section to a group home on behalf of a resident during the pendency of an appeal by or on behalf of the resident under G.S. 108A-70.9A. (6) The Department shall terminate all monthly payments pursuant to this section on June 30, 2015, or upon depletion of the funds appropriated in this act to the Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section, whichever is earlier. (7) Each group home that receives the monthly payments authorized by this section shall submit to the Department a list of all funding sources for the operational costs of the group home for the preceding two years, in accordance with the schedule and format prescribed by the Department. (Senate Bill 744-Ratified Session Law 2014-100 Page 69.)

Bridge Funding Across the State Paid to Group Homes

TABLE I. BRIDGE FUNDING EXPENDITURES BY LME/MCO

LME/MCO	INITIAL ALLOCATION OF BRIDGE FUNDS	EXPENDITURE OF FUNDS THROUGH FEBRUARY 1, 2015	DE-ALLOCATION AS OF FEBRUARY 18, 2015	RE-ALLOCATION AS OF FEBRUARY 18, 2015	ANTICIPATED YEAR END EXPENDITURE FOR SFY 2015
ALLIANCE	$397,351	$207,078			$397,351
CARDINAL INNOVATIONS	$466,887	$466,887		$39,600	$506,487
CENTERPOINT HUMAN SERVICES	$67,881	$50,609			$67,881
COASTAL CARE	$16,556	$5,572	($5,400)		$11,156
EAST CAROLINA BEHAVIORAL HEALTH	$127,483	$127,483		$39,600	$167,083
EASTPOINTE	$322,848	$109,869	($153,000)		$169,848
PARTNERS BEHAVIORAL HEALTH	$117,550	$117,550		$39,600	$157,150
SANDHILLS CENTER	$294,702	$130,413			$294,702
SMOKY MOUNTAIN CENTER	$188,742	$188,742		$39,600	$228,342
TOTAL	**$2,000,000**	**$1,404,203**	**($158,400)**	**$158,400**	**$2,000,000**

Bridge Funding as a Revenue Stream

Group homes that received bridge funding had several different revenue streams supporting their operations. The entire $2,000,000 allocated for supplemental funding by the legislature for SFY 2014-2015 will be earned in this current fiscal year and does represent a significant source of income for some of these homes. Some group homes ultimately would either have to change their business model to make up for the loss of revenue or close the group home. The closing of group homes weakens our continuum of care by reducing the availability of a needed residential service. It also should be noted that Cardinal Innovations, East Carolina Behavioral Health, Partners Behavioral Health Management and Smoky Mountain Center had depleted their supplemental funding by January 2015. The Division of MHDDSAS had also determined by February 2015 that Eastpointe and Coast Care projected that they would have excess supplemental funds of $153,000 and $5,400 respectively. The total amount of these excess funds of $158,400 was re-allocated by the Division of MHDDSA to the four LME-MCOs that had already depleted their allocations by January 2015. Each of those four LME-MCOs received additional supplemental funding allocations of $39,600 as shown in the above chart. DHHS is working on methods with the LME/MCOs that will help stabilize group homes while transitioning to the options listed in the recommendations provided.

Funding Sources of Group Homes

Group homes use a variety of funding streams. They vary widely by provider, home, LME/MCO, and by individuals in the home. None of the group homes or individuals have access to all of these funding streams. Some providers only receive SA and SSI. The following are the major sources of funding:

Special Assistance (SA) – Special Assistance is a funding source for many group homes and is used to pay for basic services.

Supplemental Security Income (SSI) – SSI is a Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income to meet basic needs for food, clothing, and shelter.

General Assembly Appropriated Non-Medicaid Funds – Sometimes referred to as IPRS funding, these funds vary greatly by LME/MCO and are available for a subset of group homes and not others. They provide for basic support in the group home.

Innovations Waiver Funding – For people with intellectual and/or developmental disabilities, the Innovations Waiver can be used to provide services for people in group homes. Waiver funds cannot be used for room and board.

Enhanced Mental Health Services – Medicaid enhanced services (for example Assertive Community Treatment Team) can be used to support people living in group homes based upon medical necessity. These services are not a substitute for the basic support a person may need to successfully live in a group home.

Other Government and Private Funds - Some group home providers use funding from other government sources to supplement the funds available from our service system. These are generally local or federal grants. Additionally, many providers supplement the group home services through private fundraising efforts.

Private Funds - Some providers supplement group home services through private fundraising efforts.

Personal Care Services (PCS) – PCS is provided for Medicaid beneficiaries who have a medical condition, disability, or cognitive impairment and demonstrate unmet needs for hands-on assistance with qualifying activities of daily living (ADLs). Qualifying ADLs for the purposes of this program are bathing, dressing, mobility, toileting, and eating. PCS cannot be provided when the beneficiary's primary need is housekeeping or homemaking. PCS must be provided in the beneficiary's private residence or residential setting. If a beneficiary receives PCS through the Innovations Waiver, the same restrictions are not applicable.

Miscellaneous – Group homes also reported other sources, including private pay and third party insurance payments. These do not represent a significant amount of funding.

CONCLUSION

The information and recommendations in this report indicate that group homes continue to be an important part of our MHDDSAS community system. The importance of a stable place to live can never be overstated. Changes in state and federal programs continue to create challenges for the homes and the residents they serve.

DHHS engaged stake holders from across the spectrum to assist in understanding the issues and help in providing recommendations. The stakeholders provided significant input to the process and are committed to continue working with DHHS to implement recommendations and to continue working on solutions to the issues.

Though we believe the recommendations will improve our system there is no one answer and we must continue to evolve our system to meet the challenges faced by providers and the individuals needing these services.