Group Home Stabilization and Transition Initiative

Session Law 2021-180, Section 9F.14

Report to

Joint Legislative Oversight Committee on Health and Human Services

Joint Legislative Oversight Committee on Medicaid

by

North Carolina Department of Health and Human Services

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I. Background

Session Law 2021-180, SB105, Sec. 9F.14 (see ***Appendix A***) directed NC Department of Health and Human Services (DHHS) to incentivize the use of 'in lieu of' services or other Medicaid-funded services to support the residential needs of Medicaid recipients in licensed, community-based group homes for individuals with intellectual or other developmental disabilities as well as those with a primary diagnosis of mental illness. Under SL 2021-180, the rate for this service should be comparable to, or a percentage of the North Carolina Innovations waiver rate and shall include wage and hour increases for direct support personnel working in these group homes. The service shall be implemented by July 1, 2022. The Session Law also appropriated funds to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to incentivize local management entities/managed care organizations (LME/MCOs) to implement these services and to increase the per member per month rate to facilitate the transition to these new services.

Section 9F.14(b)(5) directs DHHS to report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and Health Choice on the service model for residents of licensed, community-based homes that has been developed. This report provides an update on development of the new service model.

II. Incentivize LME/MCOs

The legislation requires DHHS to incentivize LME/MCOs to develop and implement new "in-lieu-of" services, or other Medicaid-funded services, to support the residential needs of Medicaid recipients living in licensed, community-based group homes. To address this requirement, the Division of Health Benefits examined the Medicaid State Plan to determine which existing state plan service types, in lieu of services, and/or (i)-option services could be enhanced such that LME/MCOs could increase financial support for the residential needs of Medicaid recipients in licensed, community based group homes for individuals with intellectual or other developmental disabilities and those with a primary diagnosis of mental illness. As a result of this examination, the Division of Health Benefits has determined that an In Lieu of Service (ILOS) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and a 1915(i) service, Individual and Transitional Supports, are the only viable mechanism for meeting this mandate.

A. State Plan

There are currently no services under the Medicaid State Plan for long term residential supports for adults with mental illness, nor are those services permitted in 1905(a) of the Social Security Act[1] as mandatory or optional Medicaid services. For I/DD, the only State Plan service with a residential component is ICF-IID. Therefore, there is not a State Plan solution to meet the directive.

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191224dl.pdf

B. In Lieu of Services (ILOS)

ILOS are services coverable under 42 CFR § 438.3(e)(2)[2], which states:

> An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:
>
> **(i)** The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
>
> **(ii)** The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting.

There are no services in the NC Medicaid State Plan which would be medically appropriately/cost effectively substituted by a residential support for adults with mental illness. A State Plan service must exist in order for an ILOS to be developed but the Social Security Act does not authorize such a service as explained above. Therefore, an ILOS for residential support for adults with mental illness cannot be created.

C. ILOS for ICF-IID and 1915(i) Individual & Transitional Supports (ITS)

Currently, all of the LME/MCOs have elected to offer ILOS for ICF-IID for adults with Intellectual/Developmental disabilities. These services can be offered to beneficiaries who meet ICF-IID level of care who are residing at home, in Alternative Family Living arrangements (AFLs), and in group homes as an alternative setting of care. As all of the LME/MCOs have either operationalized this ILOS or have received approval to do so the Division of Health Benefits has identified this service as a viable mechanism for meeting the legislative mandate to increase financial support for the residential needs of Medicaid recipients in licensed, community-based group homes for individuals with intellectual or other developmental disabilities.

The 1915(i) state plan option (hereinafter “1915(i) option” or “(i) option”) allows for states to offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. The State is able to target the HCBS benefit towards one or more specific populations, such as individuals with IDD, and establish additional needs-based criteria for eligibility (see Appendix B). The State Medicaid agency must submit a State Plan amendment (SPA) to CMS for review and approval to establish a 1915(i) HCBS benefit.

The (i) option benefit cannot be targeted by living arrangement, so any (i) option service must be available to beneficiaries residing both in private homes with their families as well as in residential settings that meet CMS-approved home and community living standards. In other words, rate increases to any one of these services would not support only beneficiaries residing in group homes, but those in group homes would be supported by the increases.

The Division of Health Benefits is in the process of transitioning the currently approved 1915(b)(3) waiver services to a 1915(i) option for the implementation of BH I/DD Tailored Plans. Under the (i) option, a service currently known [in 1915(b)(3)] as Individual Support will transition to a similar service called Individual and Transitional Supports (ITS) that can be used by adults aged 18 and older with a diagnosis of Serious Mental Illness (SMI) or Serious Persistent Mental Illness (SPMI) with at least one deficit in an instrumental activity of daily living (IADL). This is a service that would be appropriate for adults residing in group homes. It is not a per diem residential service, but it is intended to support the beneficiary in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in employment, education, community life, maintaining

[2] https://www.law.cornell.edu/cfr/text/42/438.3

housing and residing successfully in the community. By targeting provider rate increases to ITS [once the (i) option is approved; prior to that, increasing rates for the 1915(b)(3) Individual Support], Division of Health Benefits can meet the legislative mandate to increase financial support for the residential needs of Medicaid recipients in licensed, community-based group homes for individuals and those with a primary diagnosis of mental illness.

III. Establish New Rate Models and Methodologies/ Maintaining Existing Rate Structure

A. State-Funded Services

The legislation directs that DHHS establish new rate models and rate methodologies to replace the currently inadequate and insufficient State-funded rates supporting residents of licensed, community-based group homes.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services' state-funded services are currently offered across all disability groups to support individuals who are uninsured, underinsured, ineligible for Medicaid services or who do not meet medical necessity criteria for the new "in-lieu-of" services, or other Medicaid-funded services. In the event that a current service definition does not meet the need of the catchment area, the LME/MCO may submit an alternative definition request. Once approved, other LME/MCOs may choose to add this to their benefit plan. Individuals may access state-funded services upon availability of funding.

The rates for State-funded Residential Supports Levels 1-3 were updated effective June 1, 2022 by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The rates are based on Support Needs Assessment Profile or Supports Intensity Scale scores, staffing requirements, training, required accreditations, travel costs and administrative fees. The maximum rate allowed by the State is $325.00 for all levels of Residential Supports. LME/MCOs have rate setting authority and may pay a rate up to 3 times the state established rate without Division notifications. The LME/MCO may also submit a rate request to exceed 3 times the amount provided. This is submitted by the LME/MCO to the DMH/DD/SAS budget and finance office, who confer with the subject matter experts to provide a written response of support or concern.

B. Medicaid Services

As noted in the section above, the Division of Health Benefits plans to add a service option to the Medicaid state plan that would provide a means to increase funding for supports for adults with mental illness who are residing in group homes. The 1915(i) option, planned to launch with the BH I/DD Tailored Plans, will include a service called Individual and Transitional Supports [ITS, which will replace the current Individual Support, a 1915(b)(3) waiver service)] that can be used by adults aged 18 and older with a diagnosis of Serious Mental Illness (SMI) or Serious Persistent Mental Illness (SPMI) with at least one deficit in an instrumental activity of daily living (IADL). ITS is a service that would be appropriate for adults residing in group homes. It is not a per diem residential service, but it is intended to support the beneficiary in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in employment, education, community life, maintaining housing and residing successfully in the community. Effective December 1,

2022, LME/MCO capitation rates will reflect an expected increase of 31.6%[3] to the rate for Individual Support providers; while the state cannot require the LME/MCOs to increase the provider rates (since the service is not required, as noted above), the LME/MCOs will be expected to implement these provider rate increases consistent with the legislative charge. When Tailored Plans launch, and the 1915(i) option replaces the 1915(b)(3) waiver, the increased rates for Individual Support will transition to the ITS service.

C. Identify/Fill Vacant Beds

The legislation also directs DHHS to identify any vacant beds and eligible individuals to fill those beds under the new rate models and rate methodologies and to assist with the orderly transition of eligible individuals into the vacant beds. Division of Mental Health, Developmental Disabilities and Substance Abuse Services and Division of Health Benefits are working together to develop a bed registry to identify open beds. It is important to note that under the HCBS final rule, the provider/placement can be offered to the beneficiary, but the beneficiary is empowered to choose the provider/placement.

IV. Increase in Per Member Per Month Payments

The legislation directs DHHS to increase the existing per member per month payments to LME/MCOs to quickly enable and facilitate the transition to a more appropriate and sustainable service-funding model for licensed, community-based group homes by July 1, 2022. Per the legislation, "[f]unds expended under this subdivision shall be allocated in per person amounts, to be determined by DHHS, to individuals with intellectual or other developmental disabilities who received State funding prior to July 1, 2022, and who reside in licensed, community-based group homes for eligible individuals with intellectual and other developmental disabilities."

As noted in the section above, effective December 1, 2022, the capitation rates for LME/MCOs will reflect an increase of 31.6% for each of the two targeted services (ICF-ILOS and Individual Support). The $30 million (state + federal) addition to the capitation rates represents a total average impact of +0.7% to the capitation rates.

V. Recommendations

To meet the mandate of SL 2020-180, section 9F.14, DHHS will utilize the $10 million in state appropriation (and the approximately $20 million in federal matching funds leveraged with it) to fund actuarially sound increases in LME/MCO PMPMs to support provider rate increases for the two CMS-approved/approvable services determined to be directly applicable to addressing the residential needs of Medicaid recipients living in licensed, community-based group homes. Based on historical data regarding utilization of these services, Division of Health Benefits' contract

[3] Per Mercer Government's *LME/MCO Rate Presentation Dec-Mar 2023 11.10.2022*, this level of increase is after statewide implementation and full ramp-up of the ICF-ILOS (December 1, 2022 capitation rate adjustments based on the expected level of ICF-ILOS ramp-up for the December 1, 2022 to March 31, 2023 period).

actuaries have determined that the additional legislative funding will support a 31.6% increase in provider rates for each of the following services:

1) ICF-ILOS (funding, as allowable, those LME/MCOs that offer/document ICF-ILOS utilization)
2) Individual Support [a current, 1915(b)(3) waiver service)], which will be replaced (pending CMS approval) by Individual and Transitional Supports (ITS; a 1915(i) option service) when BH I/DD Tailored Plans launch.

Appendix A: Session Law 2021-180, SB105, Sec. 9F.14

GROUP HOME STABILIZATION AND TRANSITION INITIATIVE

SECTION 9F.14.(a) Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars ($10,000,000) in recurring funds for each year of the 2021-2023 fiscal biennium shall be used for the following purposes only:

(1) Incentivizing local management entities/managed care organizations (LME/MCOs) to develop and implement new "in-lieu-of" services, or other Medicaid-funded services, to support the residential needs of Medicaid recipients living in licensed, community-based group homes.

(2) Establishing new rate models and rate methodologies to replace the currently inadequate and insufficient State-funded rates supporting residents of licensed, community-based group homes. The Department of Health and Human Services (DHHS) shall identify any vacant beds and eligible individuals to fill those beds under the new rate models and rate methodologies and assist with the orderly transition of the eligible individuals into the vacant beds.

(3) Increasing the existing per member per month payments to LME/MCOs to quickly enable and facilitate the transition to a more appropriate and sustainable service-funding model for licensed, community-based group homes by July 1, 2022. Funds expended under this subdivision shall be allocated in per person amounts, to be determined by DHHS, to individuals with intellectual or other developmental disabilities who received State funding prior to July 1, 2022, and who reside in licensed, community-based group homes for eligible individuals with intellectual and other developmental disabilities.

(4) Continuing the existing rate structure at the per person amounts for the 2021-2023 biennium to offset the loss of bridge funds and maintain the current financial conditions of licensed, community-based group homes that serve children or adults whose primary diagnosis is mental illness or an intellectual or developmental disability.

Group homes with only residents who are supported by the North Carolina Innovations waiver are not eligible to receive any funding under this subsection.

SECTION 9F.14.(b) DHHS shall develop a more appropriate and sustainable service model for residents of licensed, community-based group homes. In developing this service model, DHHS shall do all of the following:

(1) In cooperation with stakeholders and LME/MCOs, develop actuarially sound, needs-based rate models and rate methodologies for new "in-lieu-of" services, or other Medicaid-funded services, that will be specific to the residential support services needed in group homes serving Medicaid recipients with intellectual or other developmental disabilities and to residential support services needed in group homes serving Medicaid recipients with a primary diagnosis of mental illness. The rate methodologies shall be comparable to, or a percentage of, existing rates for similar services currently provided through the North Carolina Innovations waiver. The new rate structures shall include wage and hour increases for direct support personnel working in these group homes.

(2) In cooperation with stakeholders and LME/MCOs, develop new model service definitions specific to the residential support services needed by Medicaid recipients with mental health needs living in licensed, community-based group homes. The new

service definitions shall require the delivery of new habilitation or rehabilitation support services in the residential setting.

(3) Develop a process whereby all, or a portion of, the State funds used to support Medicaid recipients with mental illness or intellectual or other developmental disabilities living in licensed, community-based group homes prior to the implementation of the new rate structure are used for the new "in-lieu-of" services or other Medicaid services developed pursuant to this subsection. The policy shall ensure an orderly home-by-home transition process. The policy shall ensure that residents who are found to be ineligible for Medicaid services or who do not meet medical necessity criteria for the new "in-lieu-of" services, or other Medicaid-funded services, shall continue to be served using State funds at a need-based rate comparable to the North Carolina Innovations waiver rate. No resident shall be displaced as a result of being found ineligible for Medicaid services after the implementation of the new "in-lieu-of" services or other Medicaid-funded services. DHHS may use a regional phased-in approach to achieve the goals set forth in this subdivision.

(4) Include a plan to direct LME/MCOs to

(i) implement "in-lieu-of" services or other Medicaid-funded services for all eligible residents with mental illness or intellectual or other developmental disabilities living in licensed, community-based group homes receiving State funds and

(ii) transition eligible residents to these more sustainable and appropriate Medicaid services.

(5) No later than March 1, 2022, report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the service model for residents of licensed, community-based group homes that has been developed.

SECTION 9F.14.(c) The more appropriate and sustainable service model for residents of licensed, community-based group homes developed in accordance with subsection (b) of this section shall be implemented by July 1, 2022. Once the model is implemented, the State funds that were used to support residents of licensed, community-based group homes prior to implementation shall be reinvested in their entirety in both the new funding model and increased rates to support and equalize wages of direct support personnel serving the residents.

Appendix B: HCBS Final Rule Key Provisions

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.