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Assessment #5

Delivering Behavioral Health Services in the Community

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Delivering Behavioral Health Services in the Community

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History of Medicaid Home- and Community-Based Services

Since the 1973 passage of § 504 of the Rehabilitation Act, Medicaid agencies and State Mental Health Agencies administering programs receiving Federal funds have been mandated to eliminate segregation of individuals with disabilities in the delivery of services. In enacting the 1990 Americans with Disabilities Act (ADA), Congress said it had found that "discrimination against individuals with disabilities persists in such critical areas as ... institutionalization."[1] The ADA, which prohibited state and local government agencies, departments, special purpose districts, and other instrumentalities from discriminating against people with disabilities in their programs, services, and activities, and the Federal regulations that implemented the ADA, accelerated the movement to eliminate segregation for individuals with physical and cognitive disabilities.

Title II of the ADA[2] mandated that public entities make reasonable modifications to their policies, practices, and procedures to allow equal opportunity for individuals with disabilities to participate, unless to do so would fundamentally alter the nature of the service, program, or activity. Title III of the ADA, governing public accommodations and services, declared it discriminatory to, directly, or through contractual, licensing, or other arrangements: (A) deny opportunity to participate in or benefit from goods, services, facilities, privileges, advantages, or accommodations; (B) provide a benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to non-disabled individuals; or (C) provide a benefit different or separate from that provided to other individuals.[3]

The Title II ADA regulations required a public entity to administer services, programs, and activities ***in the most integrated setting appropriate*** to the needs of qualified individuals with disabilities.[4] The U.S. Attorney General subsequently defined the "most integrated setting appropriate" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[5]

The Supreme Court further accelerated the movement toward integrated settings with its decision in the 1999 *Olmstead v. L.C* case.[6] The Court found in *Olmstead* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the ADA. The Olmstead Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated.[7]

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[1] 2 U.S.C. § 12101(a)(2), (3).
[2] 2 U.S.C. §§ 12131 through 12134 (Part A).
[3] 2 U.S.C. § 12182(b)(1)(A).
[4] 28 C.F.R. 35.130(d).
[5] 28 CFR pt. 35, App. A, p. 450 (1998).
[6] *Olmstead,* 527 U.S. 581 (1999).
[7] Ibid.

§ 1915(c) Waivers

The *Olmstead* court noted that, "[s]ince 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program" under §1915(c) of the Social Security Act.[8] In fact, the Court noted, the Department of Health and Human Services (HHS) often approves more slots under a waiver than the approved state ultimately uses.[9]

The §1915(c) waiver program provides a Federal Medicaid match to states for three years (an additional five years with the renewal of a waiver) for the provision of home- and community-based services (HCBS) to individuals who would otherwise require institutional care, but only if the average annual cost of such services is not more than the annual cost of institutional services. A §1915(c) waiver may include a waiver of the Medicaid requirement that a benefit be provided statewide[10] and/or that benefits be not less in duration, amount, or scope than benefits provided under the State Plan.[11] In addition, §1915(c) authorizes providing, for individuals with chronic mental illness, day treatment, partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

Until 2005, the §1915(c) waiver was how states most frequently promoted access to community-based services and supports. However, despite their pervasiveness, §1915(c) waivers over the years far less frequently targeted individuals with mental illness and/or related conditions than other Medicaid populations. State HCBS waivers tended to primarily address developmental disability (including autism), elderly and individuals with disabilities, individuals need who are medically fragile and need palliative care, and individuals with brain injury.

As of 2010, there were 284 § 1915(c) waivers in operation in 47 states and the District of Columbia. The three states not operating § 1915(c) waiver programs instead offered HCBS through their comprehensive § 1115 waiver programs.[12] However, as of August 7, 2014, 16 states were operating 18 separate § 1915(c) waivers for individuals with mental illness, while 18 states offered 22 § 1915(c) waivers for individuals with brain injury. There were 55 separate 1915(c) waivers for individuals with autism in 32 states, either separately or as part of larger waivers designed for individuals with developmental disabilities.[13] The robustness of the service packages varied by state, with descriptions of services in the following Montana and Wisconsin approved waiver applications indicating those states aspire to offer the most robust packages of services.

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[8] 42 U.S.C § 1396n(c).
[9] *Olmstead*, 527 U.S. 581 (1999).
[10] 42 U.S.C. § 1396a(a)(1).
[11] 42 U.S.C. § 1396a(a)(10)(B).
[12] Kaiser Family Foundation, Total Number of Medicaid Section 1915(c) Home and Community-Based Services Waivers (updated May 27, 2014), http://kff.org/medicaid/state-indicator/total-number-of-medicaid-section-1915c-home-and-community-based-services-waivers/.
[13] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml.

Montana's Adults with Severe Disabling Mental Illness Waiver affords enrollees adult day health, case management, day habilitation, homemaker services, prevocational services, residential habilitation, respite care, supported employment, occupational therapy, adult residential care, chemical dependency counseling, handling of chores, dietitian/nutrition/meals, habilitation aides, illness management and recovery, non-medical transportation, personal assistance service/specially trained attendant care, a personal emergency response system (PERS), private duty nursing (and registered nurse supervision), psychosocial rehabilitation, specialized medical equipment and supplies, and supported living.[14]

Wisconsin's Children's Long Term Support Serious Emotional Disturbance Waiver offers enrollees consumer education and training, day services, respite care, support and service coordination, supported employment, supportive home care, consumer- and family-directed supports, functional movement screens (FMS), adaptive aids, adult family home care, children's foster care/treatment foster care, communication aids, community integration, consultative behavioral intervention, counseling and therapeutic services, daily living skills training, early intensive behavioral intervention, home modifications, housing counseling, housing start up, mentoring, nursing, PERS, specialized transportation, and specialized medical and therapeutic supplies.[15]

CMS maintains a dynamic spreadsheet of all pending and approved § 1915(c) waivers, including those designed to service individuals with mental illness, brain injury, and autism at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml .

§ 1915(i) State Plan Option

Under §6086 of the Deficit Reduction Act of 2005 (the DRA),[16] Congress enacted a State Plan option under § 1915(i) of the Social Security Act[17] permitting states to serve individuals in the most integrated setting without need for a waiver or a showing of a need for an institutional level of care. States implementing § 1915(i) HCBS services would no longer need to meet the "cost-neutrality" standard required for § 1915(c) HCBS waiver services, alleviating the need for the state to produce cost estimate comparisons for institutional care and the State Plan benefit.[18] However, as enacted by the DRA, states were unable to target § 1915(i) services to particular populations within the state, and could only serve individuals whose incomes did not exceed 150 percent of the Federal poverty level (FPL). Additionally, the original service package available under § 1915(i) included some, but not all, of the HCBS available through waivers. To make the State Plan Option more attractive, Congress made changes to the § 1915(i) authority in § 2402(b) of the Affordable Care Act (ACA).

[14] MT Adults with Severe Disabling Mental Illness Waiver (0455.R01.00).
[15] WI Children's Long Term Support SED Waiver (0415.R02.00).
[16] P.L. 109-171 (Feb. 8, 2006).
[17] 42 U.S.C. § 1396n(i).
[18] 79 Federal Register 2948, 2951 (January 16, 2014).

The ACA modifications to § 1915(i) specifically allowed states to:

- provide services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR) who would otherwise be eligible for HCBS under a § 1915(c) , (d), or (e) waiver or § 1115 demonstration program;
- target the HCBS benefit to one or more state-specified population groups, through one or multiple five-year § 1915(i) service packages;
- make "other services" beyond State Plan services available to the population, including behavioral supports, cognitive rehabilitative therapy, crisis intervention and counseling, health monitoring, family training, psycho-social rehabilitation services, partial hospitalization services, day treatment, and neuropsychology services; and
- allow any or all HCBS to be self-directed under an individualized plan of care driven by the beneficiary.[19]

As of August 2014, 18 states had submitted for approval State Plan Amendments (SPAs) to implement the 5-year § 1915(i) option and 12 SPAs had been approved by CMS. Arkansas, Delaware, and Maryland planned to implement the option in 2014. The District of Columbia., which was among the states whose SPA was approved earlier, also planned to implement in 2014, with Colorado planning a 2015 unveiling.[20]

States have found the option has particular promise for improving access to community-based services for individuals with mental and substance use disorders, a group which, as noted previously, has generally been under-represented in waiver populations. For instance, Montana's §1915(i) program, for Youth with Serious Emotional Disturbances, approved by CMS in September 2013, is designed for Medicaid-eligible youth, ages 5 through 17, or until age of 20 if the youth is still in secondary school and consents to participation. A participating youth must have had at least one admission to a Psychiatric Residential Treatment Facility (PRTF), a local in-patient hospital related to behavioral health needs, or a therapeutic group home in the previous 12 months, or be at risk of placement in a PRTF, and also be receiving three or more of the following types outpatient services: outpatient therapy with or without medication management; comprehensive school and community treatment; day treatment or partial hospitalization; therapeutic family care or therapeutic foster care; or respite.

The Montana Youth with Serious Emotional Disturbances program offers:

- peer-to-peer services provided by community agencies to support the youth in making informed independent choices, coach the youth in developing systems advocacy skills, and assist the youth and his/her family in developing formal and informal community supports;
- consultative clinical and therapeutic services by treating physicians and mid-level practitioners with access to psychiatric expertise and consultation in the areas of diagnosis, treatment, behavior, and medication management;

[19] State Medicaid Director Letter (SMDL) #10-015 (August 6, 2010)
[20] Ibid.

- supplemental supportive services and goods not reimbursed by Medicaid (limited to $1,000 annually);
- education and support services for family members and unpaid caregivers that include instruction about the diagnostic characteristics and treatment regimens for the youth, including medication and behavioral management;
- a family support specialist for the youth's family unit, to provide: family therapy; education about the youth's illness; coaching, supporting and encouraging parenting techniques; providing parenting skills specific to the child; participating in family activities to change family dynamics; working with youth to access wellness recovery tools; and serving as a member of a crisis intervention team;
- face-to-face, individual, and family in-home therapy for the youth and his/her parents that includes developing and writing an individual treatment plan, providing 24/7 crisis response, assisting with transition planning, and attending family and team meetings;
- transportation by agencies through common carrier or private vehicles to and from social or other nonmedical activities included in the service plan;
- short-term respite care for the youth when the unpaid persons normally providing day to day care for the youth are not available to provide care;
- high-fidelity wraparound facilitation, comprised of a variety of specific tasks and activities designed to support the family and youth in identifying, prioritizing, and achieving their goals within a team of the family's choosing, under the supervision of a licensed mental health professional;
- specialized evaluation services with brief consultation otherwise unavailable or not covered by State Plan Medicaid or other funding sources;
- crisis intervention services, which include a short-term (not greater than 14 days) placement in a therapeutic group home or youth shelter home when intervention and short-term placement are necessary to avoid escalation and acute care admission; and
- co-occurring services, provided by a licensed addiction counselor in conjunction with a licensed mental health professional, that are designed to provide assessment/evaluation, education and treatment for co-occurring mental health and chemical dependency issues through an integrated approach.[21]

The Indiana Home and Community Based Service- Behavioral and Physical Health Coordination § 1915(i) SPA, implemented retroactively April 1, 2014 after approval by CMS on May 30, 2014, works concurrently with an earlier-approved § 1915(b)(4) waiver to allow for selective contracting of providers of behavioral and physical health coordination, specifically community mental health centers (CMHCs). The § 1915(b)(4) waiver provides for Adult Mental Health Habilitation and Behavioral and Primary Healthcare Coordination Services. The § 1915(i) coordination service is to be provided for beneficiaries age 19 and older with a primary mental health diagnosis who are living

[21] Montana Public Health and Human Services (DPHHS) §1915(i) Home and Community Based Services State Plan Program for Youth with Serious Emotional Disturbance (SED): Policy Manual (July 1, 2013), http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf (last accessed August 8, 2014).

in a residential setting. If the § 1915(b)(4) waiver expires, the § 1915(i) SPA is no longer valid. [22]

A beneficiary receiving the approved coordination service under the Indiana SPA must have demonstrated needs related to the management of his or her behavioral and physical health and impairment in self-management of the same, with a health need that requires assistance and coordination support. An assessment conducted by an independent, conflict-free assessment team must have assessed a need for intensive community-based care using the state's uniform assessment tool. The SPA defines "impairment in self-management of physical and behavioral health" as "a limited or impaired ability to carry out routine healthcare regiments, including taking medicine as prescribed, keeping medical appointments, maintaining linkage with a primary care provider, diet, exercise, and management of symptoms."

Beneficiaries are provided a list of providers in their geographic area from whom they may choose. Interventions are developed in collaboration with the individual, the treatment team, an—when appropriate—the beneficiary's family or guardian.[23]

§1915(k) Community First Choice State Plan Option

An additional option made available under § 2401 of the ACA was the "Community First Choice Option (CFC)," created under §1915(k) of the Social Security Act.[24] The CFC option was created to provide home and community-based attendant services and supports under Medicaid. The option requires a person-centered plan of services and supports, based on an assessment of functional need. Consumers are eligible if they eligible if they receive nursing facility services or have an income not exceeding 150 percent FPL.

CFC benefits may include HCBS attendant services—also called personal care and attendant care services—intended to enable people with disabilities and chronic conditions to remain in their homes and communities by providing them human assistance in performing (1) basic activities of daily living (ADLs), [25] (2) instrumental activities of daily living (IADLs), [26] and (3) health related tasks[27] they would accomplish independently if not for their disabilities.

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[22] Indiana State Plan Amendment 13-013 A9pproved May 30, 2014), Attachment 3.1-I.
[23] Ibid.
[24] 42 U.S.C. § 1396n(k).
[25] Basic Activities of Daily Living include eating/feeding (including chewing and swallowing), toileting, grooming, dressing, functional mobility, and bathing/showering.
[26] Instrumental Activities of Daily Living include meal planning and preparation, managing finances, light housework, and transportation; and health-related tasks, such as tube feedings, catheterization, range of motion exercises and medication administration.
[27] Health-related tasks include tube feedings, catheterization, range of motion exercises, and medication administration.

States that implement the CFC option receive a six percentage point increase in their Federal Medical Assistance Percentage (FMAP) during operation of the program. As of May 2014, 10 states had submitted SPAs to CMS to implement the CFC option.[28] However, a 2012 GAO report suggested that states seemed hesitant to apply for the CFC and other options for home and community-based services included in the ACA due to budgetary concerns, lack of infrastructure, staff overburden and related hiring freezes, relative priority among all requirements and options authorized by the ACA, and a greater focus on broader Medicaid reform.[29]

Among the states offering CFC option programs, the benefits offered vary. The Maryland Community First Choice Option program includes among its benefits personal assistance services, PERS, assistive technology, environmental assessments, accessibility adaptations, consumer training, supports planning, transition services, nurse monitoring, and home-delivered meals.[30]

In contrast, the California Community First Choice Option program provides:

- assistance with household chores, such as dusting, sweeping and mopping;
- heavy cleaning of the home to remove hazardous debris or dirt;
- meal preparation, laundry, and shopping;
- personal care services, such as eating, grooming, and bathing;
- paramedical services performed by an attendant related to the needs of the beneficiary, directed by licensed health care professionals;
- protective supervision, i.e. observing behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident; and
- yard hazard abatement, including removal of high weeds, rubbish, ice and snow, and other hazardous substances which constitute a hazard.[31]

California also provides for the acquisition, maintenance, and enhancement of skills through teaching and demonstration by social workers chosen by the beneficiary, as necessary to achieve greater independence. This support is initially limited to three months, but if the individual does not acquire the desired skills after three months, the services are re-authorized as needed in the individual's person-centered plan.

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[28] Kaiser Family Foundation, *State Health Facts: Section 1915(k) Community First Choice State Plan Option* (2014), http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/ (last accessed August 8, 2014) .

[29] U.S. Government Accountability Office (GAO). *States' plans to pursue new and revised options for home and community-based services (GAO-12-649)*. Washington, DC (2012). http://www.gao.gov/assets/600/591560.pdf

[30] Maryland Department of Health and Mental Hygiene, Long-Term Care, "Community First Choice Fact Sheet," https://mmcp.dhmh.maryland.gov/longtermcare/SiteAssets/SitePages/Community%20First%20Choice/CFC%20Fact%20Sheet%20-%20November%202013.doc (last accessed August 8, 2014).

[31] California CFCO State Plan Amendment, http://www.cdss.ca.gov/agedblinddisabled/res/CFCO-SPA_11-034(bookmarked).pdf (last accessed August 8, 2014).

The services provided under Oregon's Community First Choice Option "K Plan," in addition to ADL and IADL attendant care services, include:

- community transportation;
- electronic back-up systems or assistive devices (durable medical equipment not covered by other available resources, electronic devices – to increase or maintain an individual's independence) (limited to $5,000);
- once daily home-delivered meals (if individuals are home-bound, unable to do meal prep and have no other person available to prepare meals);
- contracted nursing services;
- training for individuals and representatives regarding employer responsibilities;
- environmental modifications (limited to $5,000); and
- transition costs for housing for individuals relocating from an institutional setting (Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD), Institution for Mental Illness for those 21 and younger or 65 and older, hospitals, or nursing facility).[32]

HCBS Regulations

On March 17, 2014, CMS adopted final regulations governing the implementation of HCBS services under§ 1915(c) waivers and the §1915(i) and (k) State Plan Options after several abortive attempts to adopt HCBS regulations for each service.[33] The regulations prohibit the siting of HCBS—residential and non-residential—in nursing facilities, institutions for mental diseases, ICF/IID, and hospitals. In addition to these specific settings, the regulations state that "[a]ny setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution."

A process is created by the regulations under which the Secretary determines through heightened scrutiny, based on information presented by the state or other parties, that the setting does not have the qualities of an institution and does exhibit the qualities of home- and community-based settings."[34] There's a presumption that services provided in institutional settings not specifically prohibited in the regulations or adjacent to or on the grounds of a public institution do not meet standards set for HCBS sites, but that presumption can be rebutted by the state as part of the state's waiver or SPA submission to CMS.[35]

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[32] K Plan "Frequently Asked Questions," Oregon Department of Human Services, http://www.oregon.gov/dhs/k-plan/Pages/faq.aspx (last accessed August 8, 2014).
[33] 79 Federal Register 2948 (January 16, 2014).
[34] Ibid, 2969, 3031.
[35] Ibid, 2968.

The presumption can be overcome by demonstrating that the setting is not one which:

- is isolated from the larger community;
- does not allow an individual to choose whether or with whom he or she shares a room;
- limits an individual's freedom of choice on daily living experiences, such as meals, visitors, and activities; or
- limits an individual's opportunities to pursue community activities. [36]

Instead, the setting must:

- be integrated in, and facilitate the consumer's full access to, the greater
- community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;
- be selected by the consumer among all available alternatives and identified in a person-centered service plan;
- be protective of the consumer's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint;
- optimize the consumer's initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- facilitate the consumer's choice of services and supports and who provides them.[37]

States submitting SPAs for new §1915(i) benefits must provide assurances of compliance with the new regulatory requirements as of the effective date of their proposed SPA. For any existing §1915(c) waivers or §1915(i) SPAs for which a state requests a renewal or amendment by March 17, 2015, the request must include a "transition plan," to be approved by CMS, describing the deliverables to be addressed and the time table—no longer than five years from the effective date of the regulatoins—for bringing the state into compliance. If a state does not have an SPA or waiver to be re-approved or amended, it must has until March 17, 2015 to submit its transition plan. Transition plans must be published by the state prior to submission to CMS to afford 30 days of public comment, and evidence of the public comment process must be included with the CMS submission.

While the final regulations apply to both residential and non-residential services, CMS acknowledged in January 2014 that there are issues specific to providing non-residential services traditionally provided in group settings which would need to be addressed in separate guidance. The agency held outreach discussions with interested stakeholders, including state Medicaid officials and Mental Health Agency directors, to gain a better understanding of the specific issues that would have to be addressed. However, the

[36] Ibid, 26384.
[37] 77 Federal Register 26362, 26383 (May 3, 2012).

guidance had still not been issued by August 2014 as agency officials continued to wrestle with how to provide services traditionally provided in group settings and involving group interaction while accommodating individual choice and preferences and any desire for the self-direction of services. The one basic principle enunciated by agency representatives was that non-residential services would have to meet all of the standards mandated for residential services, and that there would be no regulatory exceptions for non-residential services.

However, because states need to be able to describe how they will make the transition to community-based settings for non-residential services in the transition plans they must submit to CMS before March 16, 2015, and since some states have already been forced to supply bare bones transition plans with requests for extensions or amendments to existing SPAs or waivers already submitted, making the guidance available becomes more critical for states with each passing day.

Report Recommendations

1. The § 1915(i) State Plan Option and the § 1915(k) Community First Choice Option provide more opportunities for developing and financing a greater variety of home- and community-based services in a more specifically targeted manner than ever before. Yet states so far have largely been reluctant to adopt those options. Inpatient services are becoming ever-less favored by federal agencies and most members of Congress every day, and continue to face opposition from behavioral health consumer advocates, but the demand for behavioral health services is growing, as is public interest in health care options generated by the publicity around the Affordable Care Act coverage. With demand growing and the financially ability to sustain state inpatient facilities diminishing, states should be exploring ***now*** how they can partner with CMS to broaden service options in home and community settings. In doing so, states should keep in mind that State Plan Amendments generally require years to develop and months for CMS approval, but that approval process time frame can be significantly reduced when a state reaches out early in development to seek CMS input into concepts and structure. States should be reaching out to CMS officials as soon as possible for ideas on how to creatively structure home- and community-based services to maximize federal financial participation.

2. CMS has required that state transition plans for HCBS—required to be included with submitted §1915(i) and (k) State Plan Amendments and requests for extensions or amendments to existing waivers, and by all states on or before March 16, 2015—be subject to a 30-day public comment, and that the public comment period be evidenced in transition plan submissions for approval. However, stakeholder input should begin long before transition plans are published for comment. States should be reaching out now to interested stakeholders to help them shape the elements of the required transition plans by identifying potential barriers—such as workforce or service shortages—to accessing their preferred home- and community-based services and providers.

3. As states strive to develop accurate and complete plans for the transition to home- and community-based settings, it becomes ever more critical that the states have a clear picture of what CMS expects with regard to standards for the siting of non-residential services. The promised guidance setting the standards for non-residential services, promised in January 2014, is still pending, with the deadline for final initial state transition plans only months away. Existing noncompliant providers will have to be retooled, or replaced by new community-based providers, and states will have to at least generally identify in their transition plans who those providers are to be and how they will be structured. It is imperative that CMS expedite the promised guidance on non-residential services to provide clarity for states, providers and their beneficiaries wishing to outline how they will access services.