From: David Schaefer <DAS26@SCDMH.ORG>
To: TimRogers@schouse.govTimRogers@schouse.gov
angiewillis@scsenate.govangiewillis@scsenate.gov
Soura, ChristianChristianSoura@gov.sc.gov
Date: 5/21/2013 11:08:07 AM
Subject: FW: Potential Fiscal Impact - Proviso 33.34F
Attachments: Scanned from Xerox 5855.pdf
CRCF.OSS_OSCAP.pdf
CRCF.IMD.HHS.Finalreport.pdf

FYI – This is the response to information requested from State Budget Office.

From: Mark Binkley
Sent: Friday, May 10, 2013 1:08 PM
To: 'Hart, Brenda' (bhart@budget.sc.gov)
Cc: David Schaefer; Noelle Wriston; Robert Bank; Ligia Latiff-Bolet; Geoffrey Mason
Subject: Potential Fiscal Impact - Proviso 33.34F

Thanks, Brenda--

The Proviso, as currently worded, is innocuous and would not appear to portend any adverse impact on patients of DMH, and in fact appears to hold the promise to improve the quality of CRCF facilities and services; and, due to an increase in reimbursement, the accessibility of CRCF housing for those DMH patients in need of CRCF level of care.

However, SC DHHS in anticipation of this Proviso has already promulgated criteria -- see attached -- which it has announced will be effective July 1, 2013. Some of the criteria relates to what you specifically are asking about: new assessments of prospective residents, which may adversely impact some DMH patients, should DMH assess the patients as being in need of CRCF level of care, while DHHS assessment criteria results in a DHHS determination that they won't qualify for the new supplemental payments. DMH is in the process of looking at the new criteria in order to determine what number of patients we serve in CRCFs who may be at risk of losing State support under the new criteria. Also DMH made the request of DHHS to delegate to DMH the assessments of its own patients, since the criteria are medical in nature (DHHS nurses will do the assessments.) However, DHHS has denied that request, and we understand DHHS has 3 or 4 nurses to cover the entire State. Therefore, another concern is that the prior approval/assessment process could well result in delays which will prolong patient's lengths-of-stay. If there are significant delays associated with this new assessment/approval process, it could also cause patient's to lose an available placement while waiting on their assessment.

While the possible adverse impact of the new medical necessity criteria on DMH patients is still not able to be fully determined, we have been able to determine that the new announced DHHS standards for the CRCFs to participate in receipt of supplemental funding will have, and are already starting to have, a serious adverse impact on DMH patients. The new CRCF standards which DHHS has announced for participation in OSCAP were apparently promulgated in anticipation of the last sentence in Proviso 33.34F:
In addition, the department will establish Quality of Care Standards and other requirements for facilities licensed as a Community Residential Care Facility and participating in the OSS program and Medicaid Waiver services.

DMH was aware that DHHS was exploring ways to create new quality standards for CRCFs to meet as a condition to their receipt of OSS, but the announced standards for CRCFs will be problematic for many of the CRCFs which provide residential services to DMH patients, and will actually rule out participation in OSCAP for a number of the larger facilities, unless they cease caring for most of the DMH patients who reside there. Because the new DHHS-created CRCF "Quality of Care standards" – especially the so-called "not an IMD" standard -- will likely cause a substantial reduction in the number of CRCF beds available to DMH patients, the standards will have a negative impact on DMH

patients in need of CRCF level of care, and likely have significant negative impacts on DMH adult psychiatric hospitals in terms of increasing lengths of stay, which in turn will impact referring community hospital emergency departments and other community referral sources.

A copy of an DHHS power point slide presentation is attached. As the first slide states, DHHS is "transforming" their OSS and IPC programs, "radically changing ... orienting it in a new direction..."

- Ø OSS and IPC will no longer be available to new CRCF residents beginning July 1, 2013. Those current CRCF residents who currently receive OSS will continue to receive it (Tier 0 will be the new term) pending an individual reassessment of eligibility, but all residents who receive OSS will eventually have to qualify for the new programs in order to retain State supplemental funding beyond the first year (Tier 1 or Tier 2) or lose State supplemental benefits. The process of reassessment of current CRCF residents who receive OSS could take 1 to 2 years, per DHHS.

- Ø The name of the new replacement supplemental benefits program is "Optional Supplemental Care for Assisted Living Program" -- OSCAP.

The current OSS rate is $1193 per month, of which $57 is for the resident's Special Needs Allowance, which means the Operator gets $1,136 per month per resident. The current rate for SSI is $710 per month, which means for a resident with SSI, OSS pays $483 per month. [If the resident has SSA benefits instead of SSI, the amount of OSS could be more or less than $483 depending on the resident.]

Tier 0 will comprise those current CRCF residents who currently receive OSS, and they will continu receive OSS at the current rate pending a reassessment of eligibility for OSCAP. In other words, eventually, after all the reassessments, Tier 0 will go away;

Tier 1 will comprise residents who qualify for OSCAP (*such who reside in a facility which meets the OSCAP quality standards*. For new proposed CRCF residents receiving Social Security on and after July 1st, they will have to meet medical necessity criteria and receive a prior authorization (PA) to qualify for OSCAP, and as described below, even with PA they will only receive OSCAP if they reside in a facility which meets the OSCAP quality of care standards. The new OSCAP rate is proposed to be $1500 per month*, an increase of $307 per resident per month, but not only will the resident have to meet PA criteria, the resident will not be entitled to the OSCAP unless residing in a CRCF that meets OSCAP quality standards. (*Going through the budget process.)

Tier 2 will comprise residents who qualify for OSCAP (*such who reside in a facility which meets the OSCAP quality standards*) but who also have intermediate nursing care needs – essentially the same deficits that currently qualify a resident for the IPC program. For such residents, there will be an additional payment that will bring their monthly reimbursement to around $1900. This additional rate is the subject of a 1915c Waiver by DHHS.

The medical necessity criteria for Prior Authorization is mentioned on Slide 6: "One functional dependency and one cognitive impairment or two functional dependencies." SCDMH does not currently believe that most DMH patients who DMH staff identify as needing CRCF level care will have difficulty meeting this criteria, but we are in the process of reviewing patients to get a better understanding. There is some concern that the new criteria could be problematic for some forensic patients, as DMH does utilize CRCFs for forensic patients who are relatively independent in the ADLs/functioning and whose only impairment is their psychiatric disorder. Moreover, as mentioned above, we are concerned about the new requirement that a patient will have to have a prior assessment and prior authorization by DHHS before being found eligible for Tier 1 OSCAP. The prior approval/assessment process could well result in delays which will prolong patients' lengths-of-stay. If there are significant delays associated with this new process, it could also cause patient's to lose an available placement while waiting on their assessment.

And, as mentioned, DMH is very concerned about the new DHHS "Quality of Care Standards" which a CRCF must meet in order to participate in OSCAP. Even if the CRCF has Tier 1 eligible residents who meet the new medical necessity criteria, there will be no OSCAP funding if the CRCF does not meet the "Quality of Care Standards."

See Slide 10. In addition to a number of items which will cost the facility money (depending on the age/physical condition of the facility), in order to qualify, the facility cannot be an IMD, as defined by DHHS. That is, if a facility is larger than 16 beds, it cannot have a resident mix that is made up of greater than 45% of residents with a primary

psychiatric diagnosis.

- Ø A number of large – greater than 16 beds -- CRCFs which collectively currently serve approximately 300 DMH patients, and which historically have served as potential residential providers for DMH patients in need of CRCF level-of-care, might be classified by DHHS as "IMDs" (despite the fact that none of these facilities are Medicaid providers [or medical providers of any kind,]) Under the announced DHHS Quality of Care Standards DMH patients who were discharged to, and become residents in, these facilities after July 1 would not be eligible for OSCAP funds simply based on the size of the CRCF and the nature of the impairments of the residents in the facility.
- Ø Given that it's unlikely any CRCF would accept a resident for SSI reimbursement alone, and given that DMH cannot afford to provide ongoing State funds to in effect subsidize the patient's residence in a CRCF, it's clear that the so-called "not-an-IMD" criteria will significantly reduce the number of CRCF beds available to patients receiving DMH services.
- Ø That, in turn, will aggravate the already serious shortage of CRCF beds available to patients of DMH who are in need of CRCF level-of-care and whose only means of payment are their social security disability benefits (all of whom are also Medicaid beneficiaries).
- Ø The consequences of inadequate CRCF bed availability for persons with serious behavioral disorders is already having an adverse impact, including
    - Increasing the lengths of stay in DMH psychiatric hospitals, private and community hospitals and the Emergency Departments of community hospitals for individuals who are no longer in need of hospitalization, but who require the level of assistance afforded by a CRCF;
    - Increasing the wait times for individuals in a behavioral health crisis awaiting a hospital bed in a DMH hospital, or private or community hospital with a psychiatric unit, most of whom are waiting in community hospital Emergency Departments, not only to the detriment of the persons in crisis awaiting needed hospital treatment, but to the detriment of those hospital Emergency Departments and the persons who depend on them;
    - Increasing the risk to vulnerable individuals with a behavioral health disorder who are in need of CRCF level-of-care and whose only means of payment are their social security disability benefits – all of whom are Medicaid beneficiaries -- of living in a community setting that does not provide adequately for their care needs, which in turn places the individual at risk for institutionalization or at increased risk of harm;

In particular, I don't understand – never have – DHHS's concern about a CRCF which provides only the standard CRCF services being considered an IMD if larger than 16 beds with a majority of residents impaired by a mental illness. I'm aware of the 2003 letter SCDHHS solicited from CMS Atlanta, but have never found any case in the nation in which CMS has ever actually ruled a residential services facility – Assisted Living Facility – to be an IMD unless it was also a provider of on-site Medicaid services. Quoting from an earlier Legislative report on this topic:

"By 2003, it began to appear that Medicaid services to residents of South Carolina CRCFs with more than 16 beds and with a large percentage of patients with psychiatric diagnoses might be vulnerable to disallowance by HCFA, because the definition of the term IMD could logically include these CRCFs. From the Criteria in the State Medicaid Manual, group homes (or CRCFs) would be especially at risk if the facility were run or staffed or licensed by the DMH or were providing significant amounts of care to mostly residents with mental illness (50% or greater). The letter, dated November 3, 2003, from CMS to the former SCDHHS Director Robert Kerr (unequivocally saying that CRCFs could be considered IMDs) unfortunately confirmed this fear.

However, as the Committee discussed, neither CMS nor the OIG has ever found a private residential service provider which had no on-site Medicaid provider services to be an IMD regardless of the size of the facility and the number of residents who were receiving mental health services elsewhere, and such facilities exist in a large number of States and have for many years. Some of the interested parties urged the Committee to focus its concern on CRCFs larger than 16 beds in size in which Medicaid services are being provided on-site and in which a majority of the residents need of CRCF services is principally due to a mental illness." http://www.scstatehouse.gov/archives/dhhs/FinalIMDreport.pdf **

The risk of a standard South Carolina CRCF being declared an IMD remains purely hypothetical, and in our judgment is

vastly outweighed by the genuine likelihood of the adverse consequences on access and the accompanying adverse consequences to patients and hospitals that the so-called "IMD" standard will have.

Since DHHS announced these impending changes, we have already been told that some CRCFs which serve DMH patients may close or cease serving DMH patients. Here is a copy of an e-mail forwarded to me yesterday:

> From: Lourdes Teppers
> Sent: Thursday, May 09, 2013 12:48 PM
> To: Marjorie Wilson-Guess
> Subject: RE: CRCF Alpha Listing
>
> I have a CRCF that notified me that they are not going to be filling out the OSCAP application, and that the Medicaid Clients that are living there now will have to be placed in another community care home.

Bottom line: we share the same goals as DHHS – to improve the quality of CRCFs serving vulnerable adult Medicaid beneficiaries -- but when making changes the first rule should be "Do No Harm." The DHHS IMD Committee report from 2008 (quoted above) contained a number of recommendations related to reducing the size and improving the quality of CRCFs that served residents with serious behavioral disorders, but were never implemented due to the arrival of the Recession.** Unless and until we as a State are prepared to spend more to incentivize private CRCFs to provide a sufficient number of smaller, more home-like settings for all categories of disabled Medicaid beneficiaries in need of CRCF level of care, the State's Medicaid agency shouldn't be implementing a new supplement program that reduces CRCF availability to a segment of disabled Medicaid beneficiaries – behavioral health patients -- in need of CRCF level of care. Doing so not only will harm those beneficiaries, but as I already have described, will aggravate other current serious problems in the healthcare delivery system in SC.

--Mark

**"However, the committee accepted that development of new small (16 beds or less) facilities designed to care for residents whose behaviors require increased monitoring and supervision by facility staff would cost more to operate than current existing facilities, given that both costs and regulatory standards have increased over time. One projection was presented to the committee by Mr. Del Bradshaw, Certified Public Accountant, through committee member, Mr. John Owens. The projection indicated the cost of operation of a newly constructed 16 bed facility to be $40,555 per month, or more than double the average monthly facility operating cost of current small facilities.5"

.....

SCDHHS is concerned about the potential for a disallowance of the federal matching funds it claims to pay for the medical care and services for the residents covered by the SC Medicaid program. The DMH depends heavily upon the CRCF industry for community placement of individuals with mental illness that are unable to live independently. Both agencies are concerned about the quality of care and quality of life for individuals with mental illness who are unable to live independently because of mental illness. Current reimbursement rates established for OSS providers is insufficient to provide the level of staffing and care required for residents with major mental illness.

.....

Recommendations

To Address the IMD issue:

1. Secure funding to develop and pilot an additional level of care for the OSS program. This would include a standardized assessment component and reimburse facilities 16 beds or smaller in size at a higher level to meet the care needs of residents with intensive behavioral health needs and aggressive behavioral symptoms. The facility must be staffed with adequate numbers of direct caregivers trained in appropriate care approaches for these residents and provide opportunities for residents to be a part of the community. Direct therapeutic services could be provided, through DMH or other behavioral health providers, in programs of this size and cost determined. The standardized assessment would be refined through the life of the project and used to facilitate appropriate placement and provide adequate medical and social history information to the CRCF so that the facility owner/administrator knows what the individual's care needs are and that they can be adequately met in the CRCF setting. The standardized assessment process may result in an additional risk assessment by the operator.

2. Secure funding to provide incentives for new and existing OSS providers that will primarily serve people who are unable to live independently due to mental illness and receive medical coverage under SC Medicaid. The incentives should be limited to facilities with no more than 16 beds in order to eliminate the risk of IMD classification

that provide adequate care and services to meet the needs of this vulnerable population.

3. Require CRCFs that serve Medicaid recipients with more than 16 beds that primarily serve people with mental illness to ensure that the provision of Medicaid funded psychiatric treatment services are provided off-site. This will be enforced through the post-payment review process."

.....

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From: Hart, Brenda [mailto:bhart@budget.sc.gov]
Sent: Thursday, May 09, 2013 9:40 AM
To: David Schaefer; Mark Binkley; Noelle Wriston
Subject: Potential Fiscal Impact - Proviso 33.34F

We have been asked if the proviso below would have on impact the ability of your clients to meet the proposed criteria for qualification.

(F) Community Residential Care Optional State Supplement - The department shall establish policies and procedures to include establishing a facility rate per eligible beneficiary at $1,500 per month for recipients and providers who meet the requirements for the enhanced maximum OSS payment; establish eligibility criteria; and establish a methodology for increasing the personal needs allowance. The department will revise the net income limit to accommodate the change in the maximum OSS facility rate. A total of at least $10,000,000 shall be made available for this rate increase. Each recipient shall receive a minimum increase of $100 per month. All current recipients shall remain eligible for the supplement during the fiscal year.

If you need to see the entire proviso, the Senate version of the budget is now on the internet. This is needed as soon as possible for budget debate next week.

Thanks,
Brenda

Brenda Hart
Assistant Director
State Budget Division
529 Brown Building
1205 Pendleton Street
Columbia, SC 29201

803-734-2149

--Mark

From: Sam Waldrep [mailto:Waldrep@scdhhs.gov]
Sent: Friday, April 05, 2013 8:33 AM
To: Mark Binkley; Brenda Hyleman
Cc: Peter Liggett; Gloria Prevost

Subject: RE: OSCAP

We will confirm a date when Brenda returns and let you know next week.

I am doubtful this agency is going to back away from its IMD stance. Even if we did, I would say that as a State we do not need to be building/supporting "large" facilities just for ease in administration and/or to save money. The latest court ruling in NC indicates that these facilities are can be viewed as institutions. We need to be encouraging smaller, more home-like settings.

From: Mark Binkley [mailto:MWB86@SCDMH.ORG]
Sent: Thursday, April 04, 2013 3:34 PM
To: Sam Waldrep; Brenda Hyleman
Cc: Peter Liggett; Gloria Prevost
Subject: RE: OSCAP

Sam—

Yes, let's discuss weighing the potential negative impact on access to CRCF beds for patients/Medicaid-beneficiaries who have a mental illness with some of various quality criteria proposed.

I'm fine with Gloria being part of the meeting.

--Mark

From: Sam Waldrep [mailto:Waldrep@scdhhs.gov]
Sent: Wednesday, April 03, 2013 9:34 AM
To: Mark Binkley; Brenda Hyleman
Cc: Peter Liggett
Subject: RE: OSCAP

Mark-

Pete is going to talk with Tony about the contract this morning.

Concerning the meeting on OSCAP, I had hoped we addressed the concerns raised by Ligia and Marjorie last Thursday at the stakeholder meeting. Since these transformations are highly driven by improved quality in care, I suggest we invite P&A as well. Since this contract is a major oversight effort for us both and because of our financial participation in it, it seems advisable. Further, if the proviso passes and the rate increase goes through, that expectation of improved quality really becomes a charge. I realize your concern about access to care, but that needs to be weighed with quality.

From: Mark Binkley [mailto:MWB86@SCDMH.ORG]
Sent: Wednesday, April 03, 2013 7:56 AM
To: Brenda Hyleman
Cc: Sam Waldrep; Peter Liggett; Brenda Joyner
Subject: RE: OSCAP

9th: 10-12; 3:30 or later;
10th: any time;
11th: 3:30 or later;
12th: 10 or later;
16th: 10-12; 3:30 or later;
18th: any time in the morning; 3:30 or later

--Mark

From: Brenda Hyleman [mailto:Hyleman@scdhhs.gov]
Sent: Tuesday, April 02, 2013 7:23 PM
To: Mark Binkley
Cc: Sam Waldrep; Peter Liggett
Subject: RE: OSCAP

Mark,
I'm out of the office this week. Could you please send some possible dates over the next 2 weeks and we'll schedule the meeting?
Thanks,
Brenda

From: Mark Binkley [mailto:MWB86@SCDMH.ORG]
Sent: Tuesday, April 02, 2013 4:49 PM
To: Brenda Hyleman
Cc: Sam Waldrep
Subject: Re: OSCAP

Brenda—

This is in follow-up to our brief hallway discussion at the Hall Institute program a couple weeks ago. You offered to meet with us to discuss our concerns, and I would like to take you up on that offer, and would like Sam to participate if possible.

Marjorie has gathered some information about DMH patients currently residing in CRCFs to get a sense of what the impact of the changes may be.

Let me know what some dates and times might be to meet. Thanks

--Mark

From: Marjorie Wilson-Guess
Sent: Friday, March 29, 2013 10:17 AM
To: Ligia Latiff-Bolet
Subject: OSCAP

Good Morning,

DHHS reported that they changed the tiers for the CRCFs from 1,2 and 3 to 0, 1, and 2 because when they transition those that will qualify for tier 0, they will be left with tiers 1 and 2 and not 2 and 3.

DHHS is still working on the criteria that will be used to determine cognitive deficits. They indicated they will be looking at a moderate level of cognitive dysfunction to include for example, problems with memory, delirium and hallucinations. At present the criteria for functional deficit is; inability to perform an activity of daily living independently and thereby requiring limited assistance from another to perform the activity. Their nurses will be conducting the screenings and they will allegedly include other involved parties (DMH center staff, family , CRCFs) in their assessment process. They are likely to be using a test or instrument to ensure objectivity in their assessment. DHHS wanted to make sure we understood that they will be careful at applying the criteria to ensure our clients, at least most of them are not excluded. For example, clients who need to be reminded of their medications and given to them because they do not remember to take them or cannot really tell what they have to take.

At this point, OSCAP will not affect the residents that are currently in CRCFs. However, this is likely to change in a year. HHS reported that they are not aware of the number of MH clients that receive only OSS, but they have numbers for ICP recipients. Sam Waldrep stated that they were informed that CRCFs were housing homeless, prisoners and others that do not qualify for that level of care and DHHS was paying for it. Therefore, these measures will allow DHHS to have better control for payments made to CRCFs, these are going to be held to a higher standard of care through enforcement of DHEC regulations and payments will increase - $1,500.00 for level 1 and $1,900.00 for level 2. Sam was aware of our concerns and wanted to ensure that we understand that their intents are not to leave clients out of home placements, but to improve the quality of services and ensure their funds are appropriately used for the service of clients with two chronic dysfunctions (two physical or one cognitive and one physical).

P & A will be issuing a report by April 9 that includes pictures of CRCFs that are in poor condition. Gloria was also very supportive of DHHS initiative and also proposed that DHHS consider the money to follow the person when they are to move from a CRCF to a less restrictive environment, but DHHS said that they were not there yet, but maybe in the future. There is concern as to how the clients will move on if they do not have enough financial support. It was evident to all involved that the housing options for clients is extremely limited and DHHS encouraged us to seek funding to support those clients that will not be able to get OSCAP.