Services for the Developmentally Disabled

A Presentation to the Joint Legislative Oversight Committee on MH/DD/SAS
January 26, 2006
Topics to be Covered

• Definition of Developmental Disabilities
• Services available to the Developmentally Disabled
• CAP-MR/DD Waivers
• Plans to replace CBS for Medicaid-eligible people with Developmental Disabilities
“Developmental Disability’ means a severe, chronic disability of a person which:

(a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
(b) Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury [emphasis added] and is manifested after age 22;
(c) Is likely to continue indefinitely;
(d) Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
(e) Reflects the person’s need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or
(f) When applied to children from birth through four years of age, may be evidenced as a developmental delay.”
Examples of Developmental Disabilities

- Autism
- Cerebral Palsy
- Down Syndrome
- Epilepsy
- Fetal Alcohol Syndrome
- Mental Retardation
- Spina Bifida
- Traumatic Brain Injury (TBI)
State Funded Services for Developmental Disabilities

- Case Management
- Supported Living – Individual, family and group
- Supported Employment and Long-Term Vocational Supports
- Adult Day Vocational Program (ADVP)
- Developmental Day Care
- Community Based Services (CBS)/Developmental Therapy
- Guardianship
- Respite

(Note: With the exception of Case Management, CBS and Respite, these services may also be provided to people on the CAP-MR/DD waiver.)
Medicaid Funding for Developmental Disabilities Services

- Targeted Case Management
- Intermediate Care Facility for the Mentally Retarded (ICF/MR) – institutional service of 4 or more beds providing active treatment to people with “mental retardation or other related conditions.”
- Home and Community Based Waiver – authorized under Section 1915(c) of the Social Security Act - provide community based alternative services for individuals who would otherwise require the services of an ICF/MR
Eligibility Criteria for ICF/MR Services

Individuals must require active treatment AND have a diagnosis of mental retardation OR a condition closely related to mental retardation - a severe, chronic disability that meets ALL of the following conditions:

- Is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of MR and requires similar treatment/services; and
- Is manifested before the person reaches age 22; and
- Is likely to continue indefinitely; and
- Results in substantial functional limitations in 3 or more areas of life activity: Self-care, understanding and use of language, learning, mobility, self-direction, capacity for independent living.
Federal Guidelines for Home and Community Based Waivers

What is waived?

• Statewideness – can limit waiver participation to specific geographic territory
• Comparability of Services – waiver participants may receive services not available to the remainder of the Medicaid eligible population
• Income and Resource Rules – can use potential waiver participant’s income/resources only, ignoring any spousal and/or parental income/resources. “Family of one.”
• Restrictions on service provision by family members – family members (except spouses and parents of minor children) can be paid providers if they meet all other provider qualifications.
Federal Guidelines for Home and Community Based Waivers

What is NOT waived?

- Individuals participating in a waiver must meet the diagnostic/medical necessity/admission requirements of the comparable institutional service - in this case, ICF/MR

- Cost Effectiveness – cost of all Medicaid covered services rendered to waiver participants cannot exceed cost of institutional care if provided to those same people
Federal Guidelines for Home and Community Based Waivers

Other Federal requirements/guidelines:

• States may:
  • Limit participation. In fact, must be approved by CMS to serve a specific number of people and must receive additional approval to exceed that number
  • Define the service array
  • Early Periodic Screening, Diagnosis and Treatment (EPSDT) regulations for children do **not** apply to waiver services
NC’s Comprehensive CAP-MR/DD Waiver

- New waiver implemented 9/1/05
- Major changes in new waiver:
  - Eliminated individual limitation on service cost
  - Revised service definitions to eliminate “stacking”
  - Put in place procedures for uniform utilization review and allocation of waiver funding
  - Provides additional flexibility for “big ticket” items such as home and vehicle modifications
Services Available through the CAP-MR/DD Waiver

- Personal Assistance
- Home & Community Supports
- Residential Supports
- Day Supports
- Respite
- Adult Day Health
- Augmentative Communication Devices
- Individual Caregiver Training
- Home and Vehicle Modifications ($ limit over 3 years)
- Specialized Consultative Services
- Supported Employment
- Transportation
How the Waiver Works

- Budget approved each year by the GA includes funding available for CAP-MR/DD services in the upcoming fiscal year.
- Approved waiver dictates the maximum # of individuals to be served
- DMH/DD/SAS & DMA monitor individuals served, services delivered, and submit required reports, including annual cost-effectiveness data.

(Note: NC does not maintain a waiting list for waiver services. Case Managers do know who is interested and how long they have expressed an interest.)
Waiver Participants

- Case managers identify individuals who may qualify for waiver. When funding available, a physician or psychologist completes a MR-2. In addition, children must have a report of a psychological evaluation that is no more than 1 year old; adults no more the 3 years.

- MR-2 + psychological sent to Murdoch Center where psychologists determine whether or not person meets ICF/MR Level of Care (LOC).

- If ICF/MR LOC is determined, case manager is notified to begin Person Centered Planning (PCP) process.
Person Centered Planning and Cost Summary Development

- Case Managers work with consumers and families and their significant others to complete PCP
- PCP includes information on individual’s goals and objectives, the natural and community supports that assist him/her in achieving those goals, and the paid services and supports identified to assist.
- Following development of PCP, case manager completes a Cost Summary to project the annual cost of all anticipated paid services and supports
Plan Approval

• The completed PCP and Cost Summary are submitted to the UR LME for review and approval using standardized UR guidelines.
  • Plans costing less than $50,000/year are approved by a QDDP at the local level.
  • Plans costing between $50,000 - $85,000 must also be reviewed and approved by a second professional at the local level
  • Plans costing over $85,000 must be approved by DMH/DD/SAS.
• ICF/MR LOC and PCPs are reviewed at least annually
Waiver Providers

• When PCP is approved, consumer and family are offered a choice of qualified providers

• All CAP-MR/DD providers are directly enrolled with and directly bill Medicaid

• LMEs endorse new providers to ensure they meet provider qualifications prior to enrollment.
Waiver Statistics

- In SFY 2005: 6,814 individuals were served on the CAP-MR/DD waiver
- Average cost = $43,000/year
- Through December 2005 over 8,000 individuals have received CAP services
Proposed Additional CAP-MR/DD Waiver

- Current CAP-MR/DD Waiver follows a traditional service model – consumer and family choose a provider who delivers service.
- Growing movement in DD Community is self-directed services. Consumer and family can choose individual workers and, within a pre-set budget, negotiate terms of employment.
- Proposed New Focus Waiver will allow consumers to self-direct most services. Many stakeholders have participated in the development of the new waiver.
Approximately 5,000 Medicaid eligible individuals are currently receiving Medicaid-covered CBS service. CBS is being eliminated, per CMS requirement, with implementation of new State Medicaid Plan (3/20/06) and CMS would not approve an alternative service.

DHHS has identified a combination of alternatives to deal with this issue:

- Increase # served under CAP-MR/DD Waiver
- Use new Community Support service
- Use Medicaid Personal Care Services
- Use state-funded Developmental Therapy service
CBS Replacement
“Decision Tree”

Individual meets ICF/MR LOC?
- **Yes**
  - Process MR2, PCP, Cost Summary to add to Waiver
- **No**

Individual receiving CBS for MH/SA/Behavioral issue?
- **Yes**
  - Revise Treatment Plan to Community Support
- **No**

Medicaid Personal Care Services can address needs?
- **Yes**
  - Initiate referral to appropriate agency for assessment for PCS
- **No or partial**

PCS insufficient to meet all needs?
- **Yes**
  - Revise Treatment Plan for state-funded Developmental Therapy following strict UR guidelines
Projected Cost of Solutions

- Increase CAP-MR/DD Waiver
  - SFY 2006 -- $362,000
  - SFY 2007 & Beyond - $2.2 M
- Community Support – no increase in cost
- PCS – no increase in cost
- State-Funded Service
  - SFY 2006 -- $5 M
  - SFY 2007 & Beyond - $29.5 M
Questions?