# Study Increasing Group Home Services

## Session Law 2018-97, Section 3.11

**Report to**

**Joint Legislative Oversight Committee on Health and Human Services**

**Joint Legislative Oversight Committee on Medicaid and NC Health Choice**

**Fiscal Research Division**

**by**

**North Carolina Department of Health and Human Services**

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## I. Background

Session Law 2018-5, Section 11H.9A, as amended by Session Law 2018-97, Section 3.11 directed the North Carolina Department of Health and Human Services (DHHS) to develop a comprehensive plan for increased utilization of Social Security Act §1915(b)(3) services and "in-lieu-of" services as the foundation for sustained operation of licensed supervised living facilities as defined under 10A NCAC 27G .5601(c)(1) and 10A NCAC 27G .5601(c)(3).[1] Session Law 2018-5, Section 11H.9A, as amended by Session Law 2018-97, Section 3.11 also directed DHHS to submit a report that contains this plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by January 7, 2019.[2]

## II. Implementation Overview

### A. Introduction

Group homes serve a vital role in providing housing options for individuals who receive services under the umbrella of DHHS. The current geographic distribution of Group Home beds [non-ICF] is largely a result of decisions made decades earlier through the Areas Program system which consisted of over 40 small regional programs. State funding for group home services were often based on the allocation of HUD section 811 site-based vouchers and federal construction funds. This report provides options for consideration by the General Assembly to address the current needs of individuals residing in supervised living situations using a combination of both 1915 (b)(3) and In-lieu of services. 1915 (b)(3) services are services that are not available to be provided through the Medicaid State Plan and are funded through Managed Care savings. In-lieu of services are cost effective and medically appropriate services that are "in lieu of" a Medicaid State Plan service that is covered in the managed care contract. The comprehensive plan details timelines for implementation impacted by federal approvals, cost of each service and combined approaches, cost and practical implications of the combined approach and additional funding needed.

### B. Estimate of Cost

#### 1. 1915 (b)(3) Services

(b)(3) services are funded through Managed Care savings and are available only for individuals who are Medicaid eligible. Therefore, using (b)(3) funding for a residential service for individuals residing in supervised living facilities would address the needs of those with Medicaid but not address the needs of individuals that are not Medicaid eligible. (b)(3) funding is an option to support group home services but it is a limited pool of funding that does not drawdown Federal matching funds. Once the savings from Managed Care is exhausted, the (b)(3) services are no longer funded for that year. Additionally, all (b)(3) services, in addition to

[1] See ***Appendix A***

[2] The historical information for this report was outlined in the Report on Group Home Funding Sustainability, submitted to the Joint Legislative Oversight Committee on Health and Human Services on August 31, 2018.

residential services, are funded from the same pool statewide. Therefore, if all these funds were spent to provide a residential services to individuals, individuals who need other (b)(3) services would not be able to receive them. This includes services such as, but not limited to:

- Respite services utilized by parents and caregivers of children with Mental Health and Substance Use Disorders and Children/Adults with Intellectual/ Developmental Disabilities,
- Community Transition services utilized for individuals with Mental Health Disorders transitioning through the Transitions to Community Living Department of Justice Settlement (DOJ) and adults with Developmental Disabilities,
- Supported Employment services utilized by adults with Mental Health Disorders and Intellectual/Developmental Disabilities and used to meet compliance with the DOJ settlement,
- Individual Support services utilized by Adults with Mental Health Diagnoses.

Currently, the amount of (b)(3) services built into the per member/per month (PM/PM) capitation rate is $10.5, which is the ceiling funding amount available, not the actual PM/PM built into SFY 2018 rates. However, the actual amount spent, based on State Fiscal Year 2018 (SFY2018) expenditures, is $5.10, or approximately $98 million, leaving (b)(3) funding available to utilize on a (b)(3) service option for individuals residing in group homes.

There are four levels of support that correspond with need in the Innovations Waiver Residential service definition. Intended outcomes of the Innovations Residential service are: increasing or maintaining the person's life skills, providing needed supervision, maximizing self-sufficiency, increasing self- determination and ensuring the person's opportunity to have full membership in his/her community. The average Innovations Waiver Residential Supports rate is $140.38 per day (51,238.70 annually). If a daily rate (b)(3) residential service was established based upon the average Innovations Waiver Residential Supports rate, the average cost would be $140.38 per day (or $51,238.70 annually). There are four levels of Residential Supports range from $100.71 to $172.88 per day based on the support needs of the beneficiary. Table 1: Total Cost for (b)(3) Residential Services details the potential number of individuals which may be served and associated costs. There are currently 4,098 licensed beds for adults with developmental disabilities in the State. Of those, 1,881 are filled with individuals who are on the Innovations waiver, so 2,217 would be potentially eligible for this service (if all had Medicaid). There are currently 1,369 licensed beds for adults with Mental Health needs. This is a potential population of 3,586 individuals residing in group homes who would need to be funded by this service. At per year cost of $51,238.70 per individual, the total for year one would be $184 million. If the current available (b)(3) funding were utilized, an additional $107 million would be needed to make up the difference, with the current spending (see Table 2 below). Additional consideration to cost will be needed should the need of individuals seeking other (b)(3) services increase in future fiscal years, as there will be no additional funding available in the (b)(3) continuum.

*Table 1:Total Cost for (b)(3) Residential Services for Adults with DD and MH Needs*

| | Potentially Eligible for this Service | Cost per Individual | Total Cost of Service |
|---|---|---|---|
| Licensed Beds utilized by Adults with DD in NC | 2,217 | $51,238.70 | $113,596,197.90 |
| Licensed Beds utilized by Adults with MH needs | 1,369 | $51,238.70 | $70,145,780.30 |
| TOTALS | 3,586 | $51,238.70 | $183,741,978.20 |

*Table 2: (b)(3) Additional Funding Needed to support residential services*

| Current Available (b)(3) Funding | Total Cost of New (b)(3) Service | Additional Funding Needed |
|---|---|---|
| $77,000,000 | $183,741,978.20 | $107,000,000 |

## 2. In Lieu of ICF-IID

As allowed by federal law, Managed Care Organizations can cover services that are 'In Lieu of' similar services covered under the State Plan. To be approved, the State must determine that the alternative service is a medically appropriate and cost-effective substitute for the existing covered service under the State Plan. The beneficiary cannot be required to use the "In Lieu of" services (ILOS). For the purposes of the report, the ILOS service which would be utilized is in lieu of services provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). This service would have to be available to all beneficiaries who met the criteria for the State Plan ICF-IID service and individuals who reside in group homes/ICF-IIDs. This could include the 12,192 individuals on the waiting list for Innovations waiver services. In FY 2017, LME/MCOs and State Developmental Centers reported approximately 3,510 individuals in ICF/IID setting.

There are currently three LME-MCOs offering In Lieu of Services for ICF-IID. For the purpose of this report, the average cost for the In Lieu of Service is based on the actual expenditures for those MCOs, $37,455.93 per year per beneficiary. This is lower than the proposed cost of the (b)(3) service noted above.

It is important to note that not all the individuals in the group home population will meet ICF-IID level of care (See Attachment B). Those who do not have an intellectual or developmental disability or who do not meet the acuity level would not be able to be funded under this option.

With 2,217 individuals potentially eligible for this service, the cost would be an estimated $83 million. The State's share of the cost would be approximately $27 million.

Based on the waiting list for Innovations, there would be an additional cost of $459 million to support those individuals. As outlined in Table 3, the State's share of the cost would be $152 million. The average growth rate of the waiting list since 2013 has been 7% so the cost by year three would be $491 million, with the State's share being $161 million.

*Table 3: Additional Cost for Individuals on Innovations Waitlist*

| Current Number of Potential IDD-GH Individuals | NC's Share of Cost | Current Number of Innovations Waitlist | NC's Share of Cost Including Waitlist | NC's Projected Share of Cost at 3-Year |
|---|---|---|---|---|
| 2,217 | $27 million | 12,192 | $152 million | $161 million |

Individuals currently receiving ICF-IID services could also access this service which would be a cost savings to the State.

## C. Estimate of Single Stream Funding Currently Utilized

For SFY2018, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) reports $29,551,905 (See Table 4) was spent on Residential Services for 1,409 individuals with a Developmental Disabilities diagnosis and $13,691,407 on 836 individuals with a Mental Health diagnosis. These numbers represent individuals being served by single stream who currently receive Medicaid. These figures represent the amount of single stream funding that could be offset by Medicaid services upon implementation of (b)(3) and/or In Lieu of Services.

*Table 4: Current Single Stream Funding Potentially Available for Match of Federal Dollars*

| Population | Number Served | SFY2018 Amount |
|---|---|---|
| **I/DD** | 1,409 | $29,551,905 |
| **Mental Health** | 836 | $13,691,407 |
| **Totals** | 2,245 | $43,243,312 |

## D. Reinvestment of Funds

An estimated $43 million in State funds currently being utilized to provide residential services could be utilized to match Federal Medicaid dollars to support (b)(3) and/or In Lieu of Services.

## E. Timeline for Implementation

### 1. (b)(3) service

To utilize (b)(3) funding for a residential service, a Technical Amendment to the (b) waiver would be needed. An amendment to the (b) waiver to add a new service would take at least 240 days. In addition, other (b)(3) services currently available may need to be removed or altered as there will not be sufficient funding for this new service in addition to existing services, which may lead to people currently receiving services losing access to them, such as supported employment.

Another consideration of (b)(3) services is that home and community-based services (HCBS) services offered under (b)(3) waiver authority must meet the HCBS final rule if they are provided in provider owned settings. CMS requires that all provider sites be fully in compliance prior to their approving of the waiver. The group homes would not be able to provide the (b)(3) service until they come into full compliance through self-assessment and onsite review. Other considerations include the cost of education/training on HCBS for group home staff and providers; additional funding for LME/MCOs and DHHS initial validation of compliance and ongoing monitoring; and system updates to the HCBS database.

Additionally, as noted in the Report on Group Home Funding Sustainability, submitted to the Joint Legislative Oversight Committee on Health and Human Services on August 31, 2018, there were 237 licensed adult mental health and 1,180 IDD licensed adult groups homes. Consideration will need to be taken, as not all group homes have a service contract with the current LME/MCOs and, under the managed care system, MCOs may have closed networks. Time will be needed for this contracting process to occur.

### 2. In Lieu of Service

To implement ILOS, the State could either create a standardized ILOS definition, as it did with DHHS' current Institutions of Mental Disease (IMD) In Lieu of Service definition; or, each LME-MCO would need to submit an In Lieu of definition and have it approved by the State. LME-MCOs are not required to provide In Lieu of Services and beneficiaries are not required to accept them. If the State were to create a definition that was accepted by all LME-MCOs, this could be accomplished within 90 -120 days. The LME-MCOs would need to make any system changes needed for new procedure codes and the rate would need to be factored into the PM/PM. It would be preferable for this to occur within the normal rate setting cycle, which begins in the fall of the previous year for an effective date of July 1.

Other consideration should be given to the HCBS final rule and the impact on the system if services are developed that are similar in nature to others, but funded differently, yet does not have to meet the HCBS federal requirements. Not considering this, would create dual systems

within the service delivery system which could be an administrative burden on LME-MCOs and service providers. It would also create a system where some individuals would have greater rights to access their community, opportunities to work, and choices about their life simply based on the funding source for services.

## F. Legislative Changes Required

Additional funding will need to be allocated to implement one, or both, of these new service definitions.

## G. Conclusion

North Carolina's community based residential services system continues to evolve. As stated earlier, the current geographic distribution of Group Home beds [non-ICF] is largely a result of decisions made decades earlier through the Areas Program system and state funding for group home services were often based on the allocation of HUD section 811 site-based vouchers and federal construction funds.

Use of HUD funding was a state/area program and private provider agreement that allocated services dollars appropriated from the General Assembly for specific projects. Although the funding lost its specific identity after the biannual legislative process, the funding stayed with the Area Program where the group home was built. Current LME/MCO funding inequities for residential and other services is an artifact of this system.

Other group homes were established with the use of State county special assistance payments and small amounts of area program funding. These homes were often designed to support people with mental illness. Some group homes were established as waiver homes using only Innovations waiver "funding". These homes rely upon Innovations waiver service array to support the individuals in the homes and rely upon other funding to support the room and board functions.

Correcting the structural issues with Group Home funding will require significant investment and a plan that addresses the funding issues, but also recognizes the changing dynamics of community need. As we address the Group home funding issue, we should also plan for additional support for smaller settings, more appropriate geographic distribution and explore alternative funding options for people needing residential supports

Utilizing both ICF-IID ILOS for those individuals with an IDD diagnosis and the (b)(3) residential service for those individuals with a MH/SUD diagnosis, would offer a solution to meeting the needs of individual across all disability groups. The cost is outlined below in Table 5.

*Table 5: Total Cost of Services (Combined Use of ILOS and (b)(3))*

| | Potentially Eligible for a Service | Cost per Individual | Total Cost of Service |
|---|---|---|---|
| ICF-IID ILOS Utilized by Adults with DD | 2,217 | $37,455.93 | $83,039,796.81 |
| ICF-IID ILOS Utilized by Individuals on Innovations Waitlist | 12,192 | $37,455.93 | $456,662,698.56 |
| (b)(3) Utilized by Adults with MH Needs | 1,369 | $51,238.70 | $70,145,780.30 |
| TOTALS | 15,778 | $126,150.56 | $609,848,275.67 |

Based on the (b)(3) funding that is available, a (b)(3) residential service could be supported, but it would leave little room for growth of this or other (b)(3) services.

*Table 6: Additional Funding Needed for (b)(3)*

| Current Available (b)(3) Funding | Total Cost of New (b)(3) Service | Additional Funding Needed for (b)(3) |
|---|---|---|
| $77,000,000 | $70,145,780.30 | ($6,854,220) |

While the utilization of (b)(3) and ICF-IID ILOS can assist with services to the group home population, there will be individuals who do not meet the criteria for either service. There will still need to be State dollars allocated for those individuals who do not meet criteria or who do not have Medicaid. The funding for (b)(3) is limited by the amount of funding currently allocated in the PM/PM which also funds other services. Care must be taken not to defund other needed services/populations that receive (b)(3) services outside of residential services in the process. Regardless of the services developed through these funding sources, they cannot be written to support only the group home population and should be written to support the spirit of the CMS HCBS final rule. A service with this large of cost requirement only being utilized for individuals residing in group homes, and not for individuals residing with their family or in homes of their own, will perpetuate institutional bias and is not the direction DHHS is seeking to move the system toward.

If the General Assembly choses to authorize additional funding for the 1915(c) Innovations waiver, this could also be of benefit as some of the individuals currently living in the group homes could access a waiver slot. It is important to note though that the slots for Innovations are 'first come, first served' and would not immediately address the need for most of the group home population.

Regardless of the services that the General Assembly chooses to fund, housing is an intrinsic component of the solution. We recommend an assessment of HUD beds in the context of their location within the state and the populations in need of that housing. There should be exploration with HUD on options for moving available funding to the locations of need. A coordinated effort of housing across funding streams is needed across all populations served by DHHS.

## Appendix A: Session Law 2018-97, Section 3.11

**SECTION 3.11.** If Senate Bill 99, 2017 Regular Session, becomes law, then Part XI of that act is amended by adding a new section to read:

"**STUDY INCREASING GROUP HOME SERVICES"**

"**SECTION 11H.9A.** The Department of Health and Human Services (Department) shall, in conjunction with stakeholders, develop a comprehensive plan for increased utilization of 1915(b)(3) services and "in-lieu-of" services as the foundation for sustained operation of licensed supervised living facilities as defined under 10A NCAC 27G .5601(c)(1) and 10A NCAC 27G .5601(c)(3). The plan shall include standardized processes, methodologies, service definitions, and rates of reimbursement for these increased services. No later than January 7, 2019, the Department shall submit a report that contains this plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division. The report shall also contain the following:

(1) An estimate of the costs associated with implementation of the plan, including Medicaid costs.

(2) An estimate of the amount of single-stream funding currently being utilized to provide State-funded services that would be replaced by Medicaid services upon implementation of the plan.

(3) A description of how the amount of funds identified pursuant to subdivision (2) of this section could be reinvested to further sustain operation of licensed, supervised living facilities as defined under 10A NCAC 27G .5601(c)(1) and 10A NCAC 27G .5601(c)(3).

(4) A time line for implementation of the plan.

(5) Any legislative changes required to implement the plan."

## Appendix B: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Level of Care

To be Medicaid-certified at an ICF/IID level of care, a beneficiary shall meet the following criteria:

1. Require active treatment necessitating the ICF/IID level of care; and

2. Have a diagnosis of Intellectual Disability per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, text (DSM-5), or a condition that is closely related to mental retardation.

A. Intellectual Disability is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.

B. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets ALL the following conditions:

a. is attributable to:

i. Cerebral palsy, epilepsy; or

ii. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of Intellectually Disabled persons, and requires treatment or services similar to those required for these persons;

b. The related condition manifested before age 22;

c. Is likely to continue indefinitely; and

d. Have Intellectual Disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:

i. Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)

ii. Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)

iii. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations) IV. Mobility (ambulatory, semi-ambulatory, non-ambulatory)

iv. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life) VI. Capacity for independent living (age-appropriate ability to live without extraordinary assistance).