Strategic Plan For Services To Individuals With Intellectual and Developmental Disabilities

Overview

Stakeholders in the programs that provide long-term services and supports ("LTSS") to individuals with an intellectual and/or developmental disability ("ID/DD") have been asked to provide the Medicaid Task Force with proposals that would result in achieving substantial cost savings in the long-term care program related to individuals with ID/DD.

The Arkansas Waiver Association ("AWA") is an association that seeks to promote quality, integrated supports to individuals with ID/DD in Arkansas. Our membership consists of advocates, persons with developmental disabilities, their families and the professionals who work in the field. Our membership is built around those who are served by, or work with, Arkansas' Alternative Community Services Home and Community Based Medicaid Waiver ("the Waiver").

The State of Arkansas is not currently meeting the LTSS needs of all individuals with an intellectual or developmental disability who desire to receive their services and supports in an integrated setting within their home and community. The primary program designed to provide LTSS to this group is the Waiver. The Waiver serves a limited number of individuals. There is currently a waiting list of around 3,000 people who are qualified, eligible and in need of Waiver services, but are not receiving Waiver services. Some individuals have been on the waiting list for as long as eight years.

Given the degree to which the needs of all individuals with an ID/DD for LTSS are not currently being met, it would be disingenuous for the AWA to make recommendations designed solely to achieve a specific cost reduction level, when it is our position that some level of increased funding will be required to address the needs of those on the waiting list for Waiver services. While the AWA does not believe that sufficient data exists that would enable us, or anyone else, to accurately calculate the fiscal impact of any of the proposals submitted by us, or by others, we do believe that there are strategies that can lead to greater levels of effectiveness and efficiency within the State's Long Term Care Program in general, and the ACS Waiver in particular. To this end, we submit the following comments, analysis and recommendations.

Strategic Planning

Strategic planning is a process. For a strategic plan to achieve a desired income, the process requires the establishment or development of goals, objectives and strategies. We have adopted the following as the basis for our presentation:

Goals
The first part of strategic planning is to set a goal. We recommend the following:

"Arkansas will provide long term services and supports in an effective and efficient manner to its citizens with intellectual and developmental disabilities such that each individual will be able to achieve their full potential and enjoy the quality of life they desire"

Objectives

The second step is to develop a set of objectives designed to achieve the goal. An appropriate objective that is designed to achieve the goal is:

To provide the right services and supports, to the right people, at the right time, in the right amount, in the right place, and at the least cost possible.

Strategies

Strategies are the specific steps to be taken to implementing the objectives.

Strategic Recommendation

1. Organizational Changes

The programs that address the LTSS needs of the various populations in the State are administered by a multitude of Divisions with the Department of Human Services ("DHS"). Without a coordinated, comprehensive or cohesive approach that encompasses the entire range of LTSS provided, there is a negative impact on the effectiveness and efficiency of each of the individual programs. We recommend:

A. Reorganize DHS to create a Division that focuses exclusively on institutions, and a Division that focuses on Home and Community Based programs.
B. The Division of Institutions would administer all programs related to nursing homes, Human Development Centers ("HDC"), Intermediate Care Facilities for Individuals with an ID/DD ("ICF/IDDD"), and the Arkansas Health Center. The goal of this Division should be the eventual privatization of each institution. For new admissions, HDCs should be considered an acute care resource rather than a continued care resource, and admission should only be for those who have accessed community care, with support, and been unsuccessful.
C. The Division of Community Based Care would administer all aging, behavioral health and ID/DD programs that provide LTSS in a home and community based setting.
D. The Div. of Community Based Care would be charged with developing coordination between programs to prevent unnecessary overlap or duplication of services. Currently, in a family home with an ID/DD individual, an aging parent and a grandchild with behavioral issues, services to the family would be provided by three different DHS Divisions, with three case managers, three service plans, three case workers, etc. The attendant care staff for the person being served by the Waiver who might be taking the ID/DD individual to the grocery store is not allowed to take the grandmother. Staff taking the grandmother to a doctor's appointment may not drop the grandchild off at school. Policies and procedures are needed whereby a family can share a worker, the duties and the cost of providing care when appropriate.
E. Move the administration of the TEFRA Waiver program from the Office of Long Term Care to the Division of Developmental Disabilities ("DDS"). Eligibility for the TEFRA Waiver and the ACS Waiver is based on a determination that the person has a statutorily defined developmental disability and requires an institutional level of care. While the criteria are identical, each Waiver program utilizes a different set of staff and psychologists to make the eligibility determinations. If a participant in the TEFRA Waiver moves to the ACS Waiver, the entire eligibility determination process is repeated. There are economies of scale and greater efficiencies available when administrative functions common to more than one program are performed by a single entity.

2. System Changes

Achieving the objective of providing the right services and supports, to the right people, at the right time, in the right amount, in the right place, and at the least cost possible requires that all ID/DD related programs be subject to comprehensive and uniform policies and procedures. We recommend:

A. *Independent Assessment*. A functional needs assessment is the key to controlling utilization. It is this process that determines the specific need for services and supports for each individual. It ensures that the right services and supports are authorized in a consistent and nondiscriminatory manner. For the assessment process to be effective, it must:

(1) Be administered to all individuals with an intellectual or developmental disability that are applying for, or receiving, Medicaid funded, Licensed/Certified DDS support services. This includes participants in any ID/DD related Waiver program, residents in any HDC or ICF/IDDD and individuals receiving services in a Developmental Day Treatment Clinic Services facility.
(2) Utilize an assessment tool that is easy to administer and is designed to reliably and accurately identify an individual's functional needs.
(3) Have been thoroughly tested to ensure that the results are statistically valid
(4) Permit a case manager and the client to develop a service plan that addresses all of the necessary services and supports identified in the assessment.

B. *Individualized Budgets*. Develop a methodology by which the assessment results can be used to create an individualized budget for each client. The methodology must ensure that:

(1) The individualized budget, or budget tier, assigned to the client is based on the specific services and supports identified by the assessment as being necessary.
(2) The projected cost of any service or support to be covered by the budget is based on the cost of providing the service or support in a home and community based setting.
(3) The individualized budgets, or budget tiers, assigned to similarly situated clients are statistically valid and nondiscriminatory.

C. *Level of Care Determination*. Eligibility for the Waiver requires a determination that the individual is in need of an institutional level of care. For all programs that require this determination, it should be made by a single entity, preferably an independent entity. The level of care determination should:

(1) Contrary to recommendations made in other proposals, not be based on factors that consider the individual's preference of setting, or the intensiveness of services and supports that may be needed.
(2) In accordance with regulatory requirements, be based solely on criteria that are no more restrictive than that applicable to admission to an HDC.

D. *Case Management.* Per recent CMS rules, waiver programs must ensure Conflict Free Case Management. This requirement prohibits case management from being provided by an entity that is furnishing direct services to the same client. Given inadequate reimbursement rates, direct service providers are not likely to be able to continue to furnish this service. Case management should be transferred to the State or a third party.

E. *Administration.* Each of the administrative policies and functions addressed in 2.A through 2.D should be made applicable to all individuals with ID/DD receiving LTSS. Each function or activity requires a significant level of staffing and technological capabilities. To achieve a greater level of effectiveness and efficiency, we recommend that all of the administrative functions listed above be performed by a single entity, such as an Administrative Services Organization ("ASO"). An ASO should be established to perform the level of care determination, administer the assessments, develop budgets based on the assessments, have case managers that coordinate with the client and direct service providers in developing an individualized service plan, and arrange for services and supports to be furnished by the direct service provider chosen by the client. By bundling the various functions under one contract for services, and taking advantages of the economies of scale that would be present, the total cost of furnishing the administrative functions would likely be less than the cost of doing so on a separate basis.

F. *Self Direction.* The AWA strongly recommends that the ACS Waiver include an opportunity for individuals to exercise a greater degree of self direction over the development and implementation of their individualized plan of care. In self directed plans, the client has greater autonomy in deciding what services and supports are most important to them. In many case, the client would be willing to accept a reduced budget allotment in exchange for not being subjected to all of the bureaucratic burdens associated with receiving services through the traditional Waiver approaches. In a self directed plan, the client chooses the staff that will be providing services and supports. The staff is hired by the client, and is essentially paid by the client from their budget. Since in almost all cases, the staff hired by the client will not be receiving the same level of benefits that an agency based employee will often, or in many cases must, receive, the reimbursement rate that the Waiver pays for attendant care can be significantly reduced. For this population there would need to be an enhanced case management and support function to assure health and safety, but it would still be potentially more cost effective in many situations.

G. *Remove Arbitrary Service Levels in the ACS Waiver*. Service plans in the Waiver are categorized into three levels; pervasive, extensive or limited. Each level has a cap on the total cost of the individual plan. An unintended consequence is that a person that is determined to need a pervasive level of care may be required to utilize certain services, e.g., 24/7 attendant care, that they may not actually need. Individualized budgets will make this recommendation unnecessary.

H. *Emphasis on Work and Supported Employment.* There is substantial evidence demonstrating that individuals with ID/DD who are able to obtain meaningful employment positions paying competitive wages not only report enjoying an increased quality of life, but that their need for ongoing services and supports decline over time. Whether through a more robust component of the ACS Waiver dealing with Supported Employment services and supports, or through other collaborative programs with different Agencies, a greater emphasis needs to be placed on integrating individuals with

ID/DD into the work place. Arkansas should adopt the work first philosophy before placing individuals in more limited settings, and should begin work-based training as a mandatory part of the school curriculum. Work needs to be one of the cornerstones to system change and development. It is currently incentivized to keep people in segregated settings, while job coaching is underfunded and job development in nonexistent. Internships to develop work skills between high school and work are not present; yet for many in this population the extra step is required, not elective.

I. *Rebalancing.* Arkansas spends proportionally more of its long term care dollars in institutional settings versus community based settings than almost all other states. It is a demonstrated fact that the average cost of institutional care is significantly more expensive than community based care. We recommend:

   (1) Future admissions to an HDC should be more tightly controlled.
   (2) No individual would be eligible for admission to an HDC on an expected long term basis until DDS certifies that (a) Waiver services have been furnished to the client, (b) no provider is capable of meeting the health and safety needs of the client, or (c) that there is no Waiver provider willing or able to provide Waiver services to the client (d) short-term evaluation, programming, and medication balancing in an HDC has not proven effective to increase community success, and should be stopped.

H. *Eliminate the Waiver Waiting List.* There are currently close to 3,000 individuals who have been determined to be eligible for the Waiver, but remain on a Waiting List to actually begin receiving services. Some have been on the Waiting List for as long as eight years. Pursuant to the Supreme Court's interpretation of the integration mandate contained in the Americans with Disabilities Act ("ADA"), which requires that services provided to individuals with ID/DD be furnished in the most integrated setting, the Court indicated that a state could establish compliance with the ADA if it demonstrates that it has, "A comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated". To address the Waiver Waiting List, we recommend that the State do one, or more, of the following;

   (1) Adopt a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings.
   (2) Direct any monies from savings realized through reforms to the DD Program to the elimination of the Waiting List.
   (3) Increase the cap on the number of people that can be served by the Waiver.
   (4) Amend the Medicaid State Plan to include the Community First Choice Option ("CFCO"). The CFCO provides for an enhanced federal match rate for services and supports furnished in a home and community based setting. These services and supports can reduce, or delay, the need for institutional placement, which furthers the objectives of Rebalancing described above.

Cost Implications.

The use of an assessment ensures that each individual is receiving the right services and supports, in the right amount and at the right time. This controls against overutilization of waiver services by an individual. It also addresses underutilization. There is no reliable data available from which it can be determined whether or not the assessment process will result in more or less needed services and supports being identified. If overutilization is a problem, then costs will decline. If underutilization is widespread, then costs will rise.

The use of an individualized budget ensures that services and supports are being furnished in the right place and for the least cost possible. Each similarly situated individual will have the same amount of money to spend on services and supports. The budget will not be impacted by a person's choice of settings. A person may choose to receive their services in an institution or in a HCBS setting, but their budget will be fixed. It is expected that total costs will decline when payments are tied to specific services and supports, and are based on them being furnished by the low cost provider. There is little, if any data, available to quantify a dollar amount of such savings.

The cost implications of using an ASO to handle many of the administrative functions related to the DD program are also hard to quantify. There are economies of scale in performing assessments, setting of budgets and making level of care determinations for the entire DD population that should result in a more efficient use of resources. On the other hand, case management is likely to cost more than before. Almost all current providers of case management report that they are losing money on the service. Even with the economies of scale available, it is doubtful that any entity will be able to furnish case management without an increase in the reimbursement rate.

The only thing that can be said with any degree of certainty is that the adoption of the strategies discussed above will help achieve the objectives of providing the right services and supports, to the right people, at the right time, in the right amount, in the right place, and at the least cost possible. In doing so, the DD program will be as effective and efficient as possible. What cannot be said with any degree of certainty is exactly what the aggregate cost implications will be, other than to say that total costs are as low as possible. The use of universal assessments may, or may not, result in decreased utilization. The use of individualized budgets may reduce costs by utilizing pricing based on the least cost provider. The use of an ASO will ensure that economies of scale are realized, but there is no assurance that the ASO will be able to perform their functions more cheaply.

Projecting a specific dollar amount of savings that might be realized by implementing the above strategies is impossible. There simply is not enough reliable data from which to make calculations. We could make a totally unsupported assumption that the strategies would result in less utilization of Supported Living or Respite services by a certain percentage amount to arrive at a derived projection. However, this "derived" projection would be nothing more than an arbitrarily plugged number. Future utilization is unknowable at this time. Whether or not an ASO will be able to reduce administrative costs in the future is also unknowable.

What we do know is that rebalancing is a critical component in any plan to reduce DD program costs. Rebalancing does not necessarily require that any, or all, of the HDCs be closed, although doing so would produce substantial savings. What rebalancing does is ensure that the reimbursement rate, based on the low cost provider, for any given service or support is uniformly applied to all recipients. This means that a person in an HDC does not receive any more money from the State than what it would cost to furnish the same necessary services through the Waiver.

We believe that the use of less restrictive supports would result in cost savings. It is "preventive" care in our system. Providing supports earlier, and preserving family unity, is more effective than waiting until there is a crisis that disrupts the family bond and the community support for the individual. It is similar to going to the cardiologist and being able to use diet and out-patient procedures before resorting to bypass surgery. More restrictive measures should only be used if all other attempts have failed. In our current system, you can get bypass surgery, but nothing beforehand.

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