Myths & Facts

about

PBH's operation of the

NC Innovations Waiver

April 2010

Myth

Managed Care is not good for people with Intellectual and other Developmental Disabilities because it will take money away from the DD system.

Fact

The NC MH/DD/SAS waiver system provides a more efficient, sustainable way to ensure that individuals with developmental disabilities have access to needed funding. The Innovations waiver receives a specific Medicaid payment for the individuals who receive services through the waiver. There is no incentive to use Innovations funding for MH/SA consumers. PBH receives 8-9.5% administrative funding. PBH has never used more than 9.5% administrative funding for administrative purposes. Another 3% administrative funding is used for Care Coordination for DD consumers. All other revenues received are used for services.

The (b) (c) concurrent waiver provides a vehicle to ensure that IDD funding remains in the service system. This is accomplished by reinvesting ICF-MR dollars in community placements as individuals choose to leave the ICF-MR. It is also accomplished though adding additional services through B-3 to address service gaps. The addition of B-3 Respite and Supported Employment have reduced the waiting list for Innovations. To date PBH has served over 400 people with B-3 services who would otherwise have been waiting.

Myth

There are no outcomes for the Innovations waiver

Fact

The National Core Indicators data shows that PBH ranks higher than most other LME's in the following key areas:

- Community Inclusion: People have support to participate in everyday community activities.
- Relationships: People have friends and relationships
- Satisfaction: People are satisfied with the services and supports they receive
- Service Coordination: Service Coordinators are accessible, responsive and support the person's participation in service planning
- Access: Publicly funded services are readily available to individuals who need and qualify for them.
- Respect/Rights: People receive the same respect and protections as others in the community
- Choice and Decision Making: People make choices about their lives and are actively engaged in planning their services and supports.
- Safety: People are safe from abuse, neglect and injury
- Health: People secure needed health services.

Myth

PBH does not offer choice of service provider to the persons they support through the Innovations waiver.

Fact

While PBH operates a “closed” provider network we have over 100 providers of services for individuals with intellectual and developmental disabilities. We also have consumer specific contracts with providers outside of our network to meet special needs of people served if we do not have providers that offer the service in our network. We are very committed to having adequate consumer choice of providers, while ensuring that we offer only providers that have proven quality records. Medicaid regulations require that that consumer choice is ensured.

Myth

The Supports Intensity Scale (SIS) is the only factor used to decide what waiver funding people will receive to fund services.

Fact

PBH adopted the adult SIS in 2005-2006. We are currently working with American Association of Intellectual and other Developmental Disabilities (AAIDD) to field test the child SIS. We have used the tool to guide the Individual Support Planning process since that time. This is one of the cornerstone assessments used during plan development by the team to guide the types of supports requested and by the Care Manager (Utilization Management) to ensure that the support needs of the person are reflected in the services authorized.

In an effort to develop a fair and consistent process to allocate waiver funding PBH will use the SIS to ***inform*** the funding process. Other states have successfully used this type of funding method.

Myth

B-3 services are given to people and only last one year and the funding is taken away.

Fact

B-3 services are extra Medicaid services that come from PBH Medicaid savings. These services are not available anywhere else in North Carolina. B-3 services have been available since 2007 when they were originally approved by CMS. B-3 services are available to individuals who are Medicaid eligible and are made available for use up to the funding PBH receives from Medicaid to provide these services. B-3 services are optional and as such not an entitlement. As demand for the B-3 services increases PBH must use utilization management tools to ensure that they can provide the services within the available funding. This means that sometimes services have to be reduced if the demand is greater than the available funding to stretch the funding across as many people as possible. PBH encourages the use of:

- Community Transition
- Peer Support
- Individual Support
- Respite
- Crisis Respite
- Supported Employment
- Psychiatric Consultation

Myth

Where have any cost savings realized through the 1915 (b/c) concurrent system gone?

Fact

Originally, all cost savings realized for the 1915 (b/c) waiver were reinvested in the service system in new 1915 B-3 optional services and the Risk Reserve. Federal Medicaid has since changed the rules and the remaining savings were deposited in our Risk Reserve or "Risk Pool". The purpose of the Risk Reserve is to ensure if cost overruns occur that there is funding available to cover this cost. The Risk Reserve is only used to fund cost overruns for mandatory services or catastrophic events. The B-3 services are not an entitlement and have to be provided within the capitation. PBH is required to maintain the Risk Reserve through their contract with the state Medicaid agency (DMA). PBH has been able to reduce waiting list through the use of the B-3 services.

B-3 Services include:

- Community Transition
- Peer Support
- Individual Support
- Respite
- Crisis Respite
- Supported Employment
- Psychiatric Consultation

Myth

PBH does not have to follow any rules or regulations in its local operation of the Innovations waiver.

Fact

Innovations is a federally approved 1915 (c) waiver. The state Medicaid agency, DMA, is responsible for ensuring that Innovations operates as specified in all federal and state regulations. DMA reports results of performance indicator data gathered by PBH to CMS on a routine basis to ensure that the waiver is performing per federal regulations. In addition, PBH is required to participate in waiver monitoring by DMA, DMH and external reviewers.

Myth

PBH retaliates against providers and consumers who voice concerns regarding services and supports administered by PBH.

Fact

PBH takes the concerns of providers and individuals very seriously. PBH has multiple ways, both anonymously and by name, that individuals and providers can make their concerns known and have issues addressed. PBH contracts with an External organization to conduct both annual Provider and Consumer surveys and has a continuous quality improvement plan to address identified concerns. PBH has regularly scheduled Town Hall forums in each of the counties to respond to questions and hear concerns.

PBH has a Grievance Process for both consumers and providers. Consumer Affairs can assist individuals and families in filing a grievances and having their concerns resolved. Providers have a self managed council that is elected by its membership that partners with PBH to discuss/resolve issues of concern. This council runs the Provider meeting held on a regular basis at PBH. Providers are also free to advance concerns through their PBH Provider Relations Manager.

Myth

PBH is making rate changes that will result in all Innovations rates being "Group" only.

Fact

Innovations periodic services (Home Supports, Community Networking, Supported Employment, Day Supports, and Respite) all currently have group and individual rates and will continue to have both with the rate changes. Individuals, who need individualized supports to meet their needs, will continue to be able to access these based on the disability related need described in their Person Centered Plan. PBH pays higher than the state's CAP-MR/DD waiver for a number of services. PBH through its waiver authority has the ability to change rates up and down to both incentivize/grow services or increase /reduce services to remain within the Medicaid funding received from the state Medicaid agency (DMA) if this funding changes.

Myth

PBH has reduced ICF-MR Beds

Fact

The LME's, inclusive of PBH do not have the authority to close ICF-MR beds. PBH has reduced our net utilization of institutional ICF-MR beds, which was our goal. We have not however reduced our utilization of community ICF-MR facilities, nor is this our intent. Since the Waiver began, 11 individuals have chosen to move from ICF-MR's into community based services, these individuals receive B-3 Deinstitutionalization services. The B-3 Deinstitutionalization services provide the same service array as the Innovations waiver.

The I/DD system cannot be managed without including ICF-MR/DD services. In a 1915 (b) (c) waiver system there are advantages to including ICF-MR's which include:

- ICF-MR/DD services are an essential part of the array of services for people with intellectual and developmental disabilities. Leaving out ICF-MR/DD services from a waiver would equate to leaving out Psychiatric Hospital Inpatient Services for Behavioral Health, except that ICF-MR/DD service costs are 4 times the costs of psychiatric inpatient services, and 50% of the PBH service funding for people with intellectual and developmental disabilities.
- ICF-MR/DD services must be used strategically to provide the highest level of services in our system - a level of care that is needed.
- Because of the flexibility that results from operating the Innovations Waiver and the Managed Care Waiver concurrently, we are able to move people out of ICF-MR/DD facilities without having to wait for vacant Innovations Waiver "slots." To date, we have successfully transitioned 11 people out of the state's institutions for people with intellectual and developmental disabilities using the flexibility available through the waiver. This is an example of what is meant by "money follows the person."
- We can also transition people from a community ICF-MR/DD facility to a home in the community, keeping the consumer with the same provider, as they often desire.