Reimbursement Methodology Used for Services Provided to Senior Dual Eligibles

Session Law 2023-134, Section 9E.26.(b)

Report to

Joint Legislative Oversight Committee on Medicaid

Fiscal Research Division

By

North Carolina Department of Health and Human Services

August 9, 2024

Contents

Background

This report is provided by the Department of Health and Human Services (DHHS), Division of Health Benefits (DHB), to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division outlining steps the Department will take to detail options to address the Reimbursement Methodology Used for Services Provided to Senior Dual Eligibles (S.L. 2023-134, Sec. 9E.26.).

> Section 9E.26. of S.L. 2023-134 documents the intent of the General Assembly to continue to address the need for changes to the Medicaid reimbursement methodology used for certain services provided to seniors aged 65 and older who are dually enrolled in Medicare and Medicaid. In consultation with relevant stakeholders, DHB is required to explore all options available to increase access to Medicaid services for dual eligibles that provide alternatives to nursing home placements, including adult care homes, special care units, and in-home living. DHB is required to take specified actions, but is prohibited from implementing any changes, new programs, or new services if implementation exceeds DHB's statutory authority under G.S. 108A-54(e)(1) or creates a recurring cost to the State that would reasonably be anticipated to exceed a future authorized budget for the Medicaid program.
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> The legislation requires the following actions by DHB:
> 1) Make a formal request to the Centers for Medicare and Medicaid Services (CMS) for coverage by the Medicare program of services provided to individuals who reside in adult care homes, assisted living settings, or special care units, or to support in-home living of older individuals.
> 2) Develop the proposed changes to the current Medicaid personal care services (PCS) under Clinical Coverage Policy 3L required to implement a per diem payment for personal care services provided in a congregate setting in a manner, similar to the payment methodology used by Washington state and outlined in the report to the Joint Legislative Oversight Committee on Medicaid entitled "Establish New Adult Care Home Payment Methodology" dated June 10, 2022.
> 3) Develop the proposed service definition and draft clinical coverage policy for Adult Care Home Congregate Care Services (ACH CCS) as a new Medicaid covered service, as outlined in the report referenced above. DHB must also develop the proposed per diem rate methodology to be used for these services and create the proposed new independent assessment tool to be used.
> 4) Identify what amendments may be needed to the 1115 waiver for Medicaid transformation or the Medicaid State Plan to provide more appropriate reimbursement for services provided to Medicaid recipients residing in adult care homes or other congregate settings.
> 5) Propose any pilot program or new Medicaid demonstration waiver to support alternatives to nursing home placement for seniors.
> 6) Design innovative payment and service delivery models, including Dual Eligible Special Needs Plans (D-SNPs) and Institutional Equivalent Special Needs Plans (IE-SNPs) for assisted living facilities and adult care homes.

In accordance with Section 9E.26.(b) of S.L. 2023-134, this report details the request to CMS and their response and provides copies of proposed changes to Clinical Coverage Policy 3L with fiscal impacts; proposed service definition and clinical coverage policy for ACH CCS with fiscal impacts; necessary amendments to the 1115 Medicaid transformation waiver and Medicaid State Plan with fiscal impact; pilot program or Medicaid demonstration waivers being proposed with fiscal impacts; draft design of innovative payment and service delivery models including special needs plans for assisted living facilities and adult care homes; a description of stakeholders involved; and information on legislative changes. The full report requirements are included in Appendix A.

Research on Coverage and Reimbursement Methodology to Support Senior Dual Eligibles

Program Background

The PCS Program is a Medicaid State Plan benefit provided under the North Carolina Medicaid Program. PCS is provided for Medicaid beneficiaries who have a medical condition, cognitive impairment or disability and demonstrate unmet needs for hands-on assistance with qualifying activities of daily living (ADLs). Qualifying ADLs are bathing, dressing, mobility, toileting, and eating.

The PCS program is designed to provide personal care services to individuals residing in a private living arrangement or in a residential facility licensed by the State of North Carolina as an adult care home, a combination home as defined in G.S. 131E-101(1a), or a group home licensed under Chapter 122C of the General Statutes and defined under 10A NCAC 27G as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency. PCS is provided in the beneficiary's living environment by paraprofessional aides employed by licensed adult care homes, home care agencies or by home staff in supervised living homes.
The amount of service provided is based on an assessment conducted by a Comprehensive Independent Assessment Entity (CIAE) to determine the individual's ability to perform activities of daily living (ADLs). The performance is rated on a five-point scale that includes totally independent, requiring cueing or supervision, requiring limited hands-on assistance, requiring extensive hands-on assistance, or totally dependent.

Beneficiaries are awarded prior approvals (PAs) for the number of service hours depending on their assessed needs. Qualifying Medicaid beneficiaries who are 21 years or older may be authorized up to 80 hours of service per month. A Medicaid beneficiary who meets the eligibility requirements for PCS and other eligibility criteria mandated by S.L. 2013-306 may be authorized for up to 50 additional hours of Personal Care Services per month for a total amount of up to 130 hours. Qualifying Medicaid beneficiaries under 21 years of age may be authorized for up to 60 hours of service per month, except if additional hours are approved under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

PCS Service Definition and Coverage

PCS Covered Tasks and Services

PCS is a non-skilled service and should not be considered as a substitute for ongoing medical treatment; PCS includes the following tasks and services:

1. Hands-on assistance to address unmet needs with qualifying ADLs;
2. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the hands-on assistance with qualifying ADLs;
3. Assistance with home management of instrumental activities of daily living (IADLs) that are directly related to the beneficiary's qualifying ADLs and essential to the beneficiary's care at home;
4. Assistance with medication when directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS as specified in Clinical Coverage Policy 3L, Subsection 3.2;
5. Assistance with adaptive or assistive devices when directly linked to the qualifying ADLs;
6. Assistance with the use of durable medical equipment when directly linked to the qualifying ADLs; or
7. Assistance with special assistance (assistance with ADLs that requires a Nurse aide II) and delegated medical monitoring tasks.

The following additional assistance may be approved under EPSDT criteria for beneficiaries under 21 years of age:

1. Supervision (observation resulting in an intervention) and monitoring (precautionary observation);
2. Cueing, prompting, guiding, and coaching;
3. After school care, if PCS tasks are required during that time and no other individuals or programs are available to provide this service; and
4. Additional hours of service authorization.

Medication Assistance

Medication assistance may be a covered service when it is:

1. Directly linked to a documented medical condition or physical or cognitive impairment causing the functional limitations requiring the PCS;
2. Delivered in a private residence and consists of medication self-administration assistance described in 10A NCAC 13J;
3. Delivered in an adult care home and includes medication administration as defined in 10A NCAC 13F and 13G; or
4. Delivered in a supervised living home and includes medication administration as defined in 10A NCAC 27G.

PCS Non-Covered Tasks and Services

Though non-skilled, PCS does NOT include the following services:

1. Skilled nursing services provided by an LPN or RN;
2. Services provided by other licensed health care professionals;
3. Respite care;
4. Care of non-service-related pets and animals;
5. Yard or home maintenance work;
6. IADLs in the absence of directly related qualifying ADLs;
7. Transportation;
8. Financial management;
9. Errands;
10. Companion sitting or leisure activities;
11. Ongoing supervision (observation resulting in an intervention) and monitoring (precautionary observation), except when approved under EPSDT as specified in Subsection 2.2;
12. Personal care or home management tasks for other residents of the household;
13. Other tasks and services not authorized in the beneficiary's Independent Assessment and noted in their Plan of Care; and
14. Room and board.

NOTE: A beneficiary may not receive PCS and another substantially equivalent federal or state funded service on the same day. Examples of equivalent services include home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Disabled Adults, CAP/Children, CAP/Consumer Direction, and Innovations. This restriction also includes any other federal or state funded service that provides assistance with ADLs Level II or Level III personal care in the home.

Medicaid does not cover PCS in licensed residential facilities when:

1. The beneficiary is ventilator dependent;
2. The beneficiary requires continuous licensed nursing care;
3. The beneficiary's physician certifies that placement is no longer appropriate;
4. The beneficiary's health needs cannot be met in the specific licensed care home, as determined by the residence; or
5. The beneficiary has other medical and functional care needs that cannot be properly met in a licensed care home, as determined by General Statutes and licensure rules and regulations.

PHASE I Accomplishments

To achieve the directive of establishing a new reimbursement methodology for PCS delivered in an adult care home (ACH) congregate care setting that is different from that of PCS delivered in the home or a private setting, it was necessary to establish a state plan PCS policy for the ACH setting as a standalone clinical coverage policy. Clinical Coverage Policy 3L-1 is in the process of being promulgated with an anticipated effective date of September 1, 2024. DHHS/DHB has submitted a companion State Plan amendment to transition PCS from the unit-based payment to a daily per diem payment to CMS which was approved on December 19, 2023 with an effective date of January 1, 2024. Subsequent changes to the PA process for claims submission in NCTracks is in development with an anticipated completion date of July 1, 2024. In the 90 days prior to the implementation of the NCTracks billing changes, ACH providers will receive training on how to use the new daily per diem billing process. These initial changes to the policy and payment methodology were accomplished with a budget neutral outcome and are prerequisites to ensuring budget predictability for subsequent changes to service definitions and the assessment tool.

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PHASE II -Plans

DHHS/DHB has convened a work group of interested providers and advocates to develop a new service definition that more appropriately aligns with the needs of individuals served in the current ACH setting (see Appendix B for a list of specific stakeholders). Following the development of the service definition, DHHS will evaluate whether the existing Independent Assessment Tool is adequate to capture the data needed to generate a reliable comprehensive assessment, service plan, and PA. Optimizing the existing legacy system would allow the State to maintain budget predictability and lessen the burden of providers who would have to adjust to a new assessment tool and process.

Under federal law, States have the option to pay for personal care and other long-term care services in residential care settings such as ACHs through the Medicaid State Plan personal care option and the home- and community-based services (HCBS) 1915(c) waiver program.

Details on any pilot program or new Medicaid demonstration waiver being proposed and any annual cost or savings to the State associated with the implementation of each proposed pilot program or demonstration waiver

Since 1975, States have had the option to offer PCS under the Medicaid State Plan in individuals' place of residence, whether in their own home or in a residential care setting such as an adult care home. Until 1993, the option was medically focused, and services had to be prescribed by a physician and delivered in accordance with a care plan. In 1993, Congress allowed States to authorize PCS providers to oversee the provision of care.

States have the authority to impose reasonable medical necessity criteria for eligibility to receive services but cannot restrict services to people who require nursing home level of care.

Because personal care is an optional Medicaid service, States have considerable flexibility in how the services are provided. While optional services must be offered statewide, States can set additional eligibility criteria for the receipt of services. As of 2018, 33 states and the District of Columbia have taken up the PCS option, but three States (Delaware, New Mexico, and Rhode Island) do not have enrollment in the program.

An advantage of using the personal care State Plan option to cover services in residential care settings is that the State can provide services to a less severely impaired population. However, providing services through the State option limits the eligibility standard to more limited income parameters than may be in place for waiver programs.

Since 1981, care in ACHs can also be provided through the HCBS waiver program. This option is more flexible, and the provision of services focuses on current licensing and regulatory provisions for residential care settings. States can design their waivers to target specific populations or limit the number of people eligible for the program. States can either amend an existing waiver to add services provided in residential care settings or they can apply for a new separate waiver to cover services in residential care settings. The HCBS waivers are intended to be, by definition, cost-effective.

Additional details on any pilot programs, new Medicaid demonstration waivers, or other State actions would need additional research before estimates on any annual costs or savings to the State could be made.

Details and a draft of any innovative payment and service delivery models developed, including Dual Eligible Special Needs Plans (D-SNPs) and Institutional Equivalent Special Needs Plans (IE-SNPs) for assisted living facilities and adult care homes

A Special Needs Plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) designed to provide targeted care and services to individuals with unique needs. "Special needs individuals" have been defined as: 1) institutionalized beneficiaries; 2) Medicare-Medicaid enrollees; and/or, 3) individuals with severe or disabling chronic conditions, as specified by CMS. Payment procedures for SNPs mirror the procedures that CMS uses to make payments to non-SNP MA

plans. CMS makes advance monthly payments, or capitated payments, to an MA organization for each enrollee for coverage of original Medicare benefits in an MA payment area.[1]

There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual Eligible SNP (D-SNP)
- Institutional SNP (I-SNP)

Currently NC Medicaid has 17 D-SNPs contracts, of that group 8 are dual I-SNP. The Department of Insurance has licensed eight Medicare Advantage I-SNPs.

About one in four dual-eligible beneficiaries in NC were enrolled in Medicare Advantage at some point over NC Medicaid's 4-year study period (2014-2017). Since 2017, D-SNP enrollment has been increasing in NC, and in 2022, 17 D-SNPs serve 1 in 3 dual-eligible beneficiaries statewide. D-SNP penetration is concentrated in central parts of the state, especially Forsyth and Guilford counties, although many counties in north central/northeastern (e.g., Edgecombe and Washington) and southeastern NC (e.g., Robeson and Cumberland) also have relatively high D-SNP penetration.

An Institutional-Equivalent Special Needs Plan (IE-SNP) is a type of I-SNP. The IE-SNP option is relatively new to CMS options for managed care for individuals who are on Medicare and Medicaid. This option targets people who need the level of care given in a long-term care facility who can remain at home. Some people eligible for IE-SNPs live in group home settings or assisted living residences.

Information on IE-SNPs, per CMS' site[2]:

- For an I-SNP to enroll MA eligible individuals living in the community, but requiring an institutional level of care (LOC), the following two conditions must be met:
    - A determination of institutional LOC that is based on the use of a state assessment tool. The assessment tool used for persons living in the community must be the same as that used for individuals residing in an institution per federal guidelines. In states and territories without a specific tool, I-SNPs must use the same LOC determination methodology used in the respective State or territory in which the I-SNP is authorized to enroll eligible individuals.
    - The I-SNP must arrange to have the LOC assessment administered by an independent, impartial party (i.e., an entity other than the respective I-SNP) with the requisite professional knowledge to identify accurately the institutional LOC needs. Importantly, the I-SNP cannot own or control the entity.

The IE-SNP's model of care, flexibility, and services are very similar to an I-SNP's; the main difference is where the plan members reside IE-SNPs are available to beneficiaries who meet the State definition for institutional level of care but are not in a Long-Term Care facility.

DHHS/DHB is seeking technical guidance from CMS about NC Medicaid's options for integrating IE-SNPs into NC Medicaid's long-term strategy for individuals who are dually eligible. Development of innovative payment and service delivery models will be informed by CMS guidance and will be provided in the next report.

Continue to assess the need for any recommended legislative changes

DHHS/DHB has not identified any recommended legislative changes at this time. DHHS/DHB will continue to assess the need for changes as it continues to engage with stakeholders.

[1] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Special_Need_Plans_SNP_Frequently_Asked_Questions-FAQ.pdf
[2] https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/institutional

Appendix A: Session Law 2023-134, Section 9E.26

CONTINUE TO ADDRESS THE REIMBURSEMENT METHODOLOGY USED FOR SERVICES PROVIDED TO SENIOR DUAL ELIGIBLES

SECTION 9E.26.(a) It is the intent of the General Assembly to continue to address the need for changes to the Medicaid reimbursement methodology used for certain services provided to seniors aged 65 and older who are dually enrolled in Medicare and Medicaid. The Department of Health and Human Services, Division of Health Benefits (DHB), shall explore all options available to increase access to Medicaid services for dual eligibles that provide alternatives to nursing home placements, including adult care homes, special care units, and in-home living, and do so in consultation with relevant stakeholders. The following actions shall be taken by DHB, but DHB shall not implement any changes, new programs, or new services if that implementation exceeds DHB's authority under G.S. 108A-54(e)(1) or creates a recurring cost to the State that would reasonably be anticipated to exceed a future authorized budget for the Medicaid program:

(1) Make a formal request to the Centers for Medicare and Medicaid Services for coverage by the Medicare program of services provided to individuals who reside in adult care homes, assisted living settings, or special care units, or to support in-home living of older individuals.
(2) Develop the proposed changes to the current Medicaid personal care services under Clinical Coverage Policy 3L required to implement a per diem payment for personal care services provided in a congregate setting in a manner, similar to the payment methodology used by Washington state, as outlined in the report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice entitled "Establish New Adult Care Home Payment Methodology" dated June 10, 2022.
(3) Develop the proposed service definition and draft clinical coverage policy for Adult Care Home Congregate Care Services (ACH CCS) as a new Medicaid covered service, as outlined in the report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice entitled "Establish New Adult Care Home Payment Methodology" dated June 10, 2022. Additionally, DHB shall develop the proposed per diem rate methodology to be used for these services and create the proposed new independent assessment tool to be used.
(4) Identify what amendments may be needed to the 1115 waiver for Medicaid transformation or the Medicaid State Plan to provide more appropriate reimbursement for services provided to Medicaid recipients residing in adult care homes or other congregate settings.
(5) Propose any pilot program or new Medicaid demonstration waiver to support alternatives to nursing home placement for seniors.
(6) Design innovative payment and service delivery models, including Dual Eligible Special Needs Plans (D-SNPs) and Institutional Equivalent Special Needs Plans (IE-SNPs) for assisted living facilities and adult care homes.

SECTION 9E.26.(b) No later than March 1, 2024, DHB shall submit a report to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division on all of the following as they relate to requirements under subsection (a) of this section:

(1) The details of the request required to be submitted to CMS and the response to the request by CMS.
(2) A draft of the proposed changes to Clinical Coverage Policy 3L and the annual cost or savings to the State associated with the implementation of those changes.
(3) A draft of the proposed service definition for ACH CSS and the associated per diem rate methodology and assessment tool. This includes the annual cost or savings to the State associated with the implementation of any or all of these items.
(4) A draft of any 1115 waiver or State Plan amendments developed in accordance with subdivision (4) of subsection (a) of this section. This includes the annual cost or savings to the State associated with the implementation of the waiver or State Plan amendments.
(5) Details on any pilot program or new Medicaid demonstration waiver being proposed and any annual cost or savings to the State associated with the implementation of each proposed pilot program or demonstration waiver.
(6) Details and a draft of any innovative payment and service delivery models developed, including Dual Eligible Special Needs Plans (D-SNPs) and Institutional Equivalent Special Needs Plans (IE-SNPs) for assisted living facilities and adult care homes.
(7) A description of the stakeholders involved in the development of any plan or proposal.

(8) Any recommended legislative changes.

Appendix B: Work group Participants

Brooke Baragona	SembraCare
Jeff Horton	NC Senior Living Association
Frances Messer	NC Assisted Living Association
Richard Rutherford	SembraCare
Tom Stahlschmidt	ALG Senior Care
Kathy Smith	Association of Home Health and Hospice
Libby Kinsey	Division of Health Services Regulations
Megan Lamphere	Division of Health Services Regulations
Wrenia Bratts-Brown	Division of Health Benefits
Katrina Brown	Division of Health Benefits
Juanita Jefferson	Division of Health Benefits
Sabrena Lea	Division of Health Benefits
Reggie Little	Division of Health Benefits

Appendix C: Draft of Clinical Coverage Policy 3L-1

The draft of Clinical Coverage Policy 3L-1 - State Plan Personal Care Services (PCS) Provided in Residential Settings can be found here: https://medicaid.ncdhhs.gov/media/13833/download?attachment.