HCBS: Getting Started with Implementation

Presentation to ACL members
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HCBS Presentation Agenda

- HCBS Framework
- How HCBS Works
- HCBS Start-up Challenges & Strategy
- Questions & Discussion
HCBS Framework
HCBS Vision & Purpose

- Created through a federal Medicaid waiver to better address the needs of consumers living in the community
- Dedicated pot of funds that Managed Care Plans (MCP) administer for 2 years outside their rate & then HCBS dollars will be merged into HARP benefits and the MCP’s rates.
- Extends Medicaid funding to employment, rehabilitation, peer, crisis and other services
- Supports service delivery in community settings that are not restricted per the CMS “Settings Rule”
- Expands Medicaid funding of beneficial service delivered by non-clinicians (e.g. rehab & employment specialists, certified peers)
HCBS Services List

- Psychosocial Rehabilitation (PSR)
- Habilitation
- Peer Support
- Family Support and Training
- Education Support
- Employment (pre-voc, transitional, ongoing, intensive)
- Community Psychiatric Support & Treatment (CPST)
- Short-term Crisis Respite
- Intensive Crisis Respite
HCBS Value to ACL Members

- ACL members serve adults with SMI and SUD who are eligible for HARP & HCBS
- HCBS addresses the functional and skills deficits that impede your clients from working, going to school, finding/retaining housing and forming/regaining supportive relationships
- Other than housing with supports, HCBS is the only new source of program growth for rehab as well as for peer and employment/educational services.
- HCBS services could be offered in any program site and in any community setting as long as they comport with the CMS “Settings Rule”.
- In 2 years, it is expected that HCBS will be an integral care component for adults with SMI/SUD.
How HCBS Works
Pathway to HCBS

- Health Home (HH) care coordination is gateway to HCBS
- HHs assess HARP enrollees for HCBS eligibility
- For those eligible, HHs develop care plan and identify HCBS provider(s)
- Some Managed Care Plans (Plans) are requiring providers to notify them before starting assessment.
- Plan approves HH care plan and HCBS provider(s)
- HCBS providers
  - Assess for duration, scope and frequency for each HCBS service,
  - Sets goals with consumer for each service,
  - Develops service plan for each service, and
  - Submits all to MCP for pre-authorization and gets approval.
- HCBS provider delivers service(s), documents delivery of each service separately and person’s progress toward goals for each service.
- If new or additional service(s) are required, the provider has to go back to HH to revise the care plan & Plan for pre-authorization.
HCBS: Challenges for Small Agencies

- Unprecedented paperwork burden compared with other Medicaid & contract-funded services
- Initially referrals will be slow because of required assessment & service planning processes
- Not easy to have your own clients referred unless your agency offers HH care coordination or has good relationships with HHs
- Only paid for face-to-face encounters based on 15 min increments
- For every billable hour, there may be hours of unbilled time
- Cannot provide program without an EHR; OMH will fund for smaller agencies but agency must maintain
- Peers and BA-level staff will be expected to document services in EHR; intense training and supervision will be needed at the start
Financial Modeling Tool
Financial Model Highlights

- Modeling tool allows agency to model cost of delivering an hour of service compared with hourly Medicaid fee.
- It is formula driven but agencies can fill in yellow and green shaded cells with their own numbers.
- Key drivers of costs are:
  - Productivity of direct care staff (paid vs. billable hours; amount of weeks & daily hours worked by salaried staff; % on-site vs. off-site)
  - Direct care staff salaries vs. use of per diem staff
  - Percentage of FTE supervisory/support staff attributed to HCBS
  - Collectible rate of claims submitted
  - Costs for fringe, A & O and rent
OMH Proposed Rate Enhancements (at CMS)

- Current rates for ROS: Downstate counties will be paid the NYC published rates and upstate counties 89% of upstate rates.
- Request pending at CMS to increase current rates by 4%.
- PSR rate may increase an additional 9% to compensate for lower productivity delivering off-site services.
- Crisis short-term and intensive respite rates may increase substantially from $306.00 to a proposed fee of $419.51 for short-term crisis respite and $476.00 to a proposed fee of $649.72 for intensive crisis respite.
- During the ramp-up period, all rates may increase as follows:
  - 50% until HCBS system-wide utilization exceeds 55% of estimated full utilization for HARP enrollees;
  - 25% until HCBS system-wide utilization exceeds 70% of estimated full utilization for HARP enrollees AND
  - 10% until system-wide utilization exceeds 85% of estimated full utilization for HARP enrollees.
Next Steps & Open Questions

Thank you for participating!

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