Behavioral Health Respite Implementation – Authority Options

June 30, 2022

Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to evaluate options for a Medicaid waiver to provide respite care for youth experiencing behavioral health challenges, as prescribed through Proviso 82. These options will provide context for HCA when evaluating potential avenues for establishing respite services under Medicaid authority with the intent to draw federal matching funds. These options should consider potential adverse impacts with respite waivers at the Department of Social and Health Services, Developmental Disabilities Administration, and the Department of Children, Youth, and Families. While Mercer and HCA recognize that financing and available federal medical assistance percentage (including temporary enhanced) may influence policy decisions, this report is intended to focus on available waiver authorities. Ongoing discussion within the State may raise additional considerations, including financing; this report can be updated as needed.

At the request of the legislature, HCA is exploring the implementation of respite services for managed care programs as well as carve-out fee-for-service (FFS) populations. Waiver options should consider applicability to both managed care and FFS programs although use of a single authority is not a requirement. Additionally, as respite services are implemented statewide, HCA should consider provider network capacity, required staffing (second staff for safety) and ramp-up time for new providers.

This report is issued in draft form as of the date indicated above. Mercer understands that HCA intends to continue discussions more broadly within the State. Mercer recognizes that new information or additional considerations may become relevant; this document can be updated as needed.

Respite Services Definition

Historical Service Encounter Reporting Instructions (SERI) Definition: Respite Care Services[1]

Use of this historical definition of respite services can be utilized as a reference point but will need to be updated based on intended program design. Further, any definitions should clearly delineate between behavioral health (BH) respite and other medical respite services administered through other programs; clearly delineating the services will also simplify coding, billing, reporting and other administrative activities. As HCA develops a more formal definition for BH respite services, this report can be updated as needed.

Currently, respite services are provided with State-only or local funding to sustain the primary caregivers of children and youth experiencing complex behavioral health needs or adults with mental illness. This is accomplished by providing observation, direct support, and monitoring to meet the physical, emotional, social, and mental health needs of children or youth by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the youth, family or caregiver's home, in an organization's facilities, in the respite worker's home, etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of a mental health professional.

Inclusions:

- Observation, direct support, and monitoring to meet needs of an enrollee by someone other than the primary caregivers.
- Service may be provided on a planned or an emergent basis.
- Service provided in a variety of settings such as the person’s or caregiver’s home, an organization’s facilities, or in a respite worker’s home.
- Service provided in a manner necessary to provide relief for the person or caregivers.
- Concurrent or auxiliary services may be provided by staff who are not assigned to provide respite care.

Exclusions:

- Respite care covered under any other federal program (e.g., Aging and Adult Services, Children’s Administration).

[1] https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2022.pdf

Overview of Authorities

Respite has generally been provided under waivers such as 1915(c), 1115, 1915(b)(3). However, the Affordable Care Act created a Medicaid State plan option under 1915(i) authority and Center for Medicare & Medicaid Services (CMS) recently authorized targeted respite services as an approved in lieu of service in California. Historically, respite services were offered in Washington under (b)(3). Examples of (b)(3) implementation include Ohio, Louisiana, and previously Washington (prior to July 2012).

Respite would likely not fit under Washington's existing or future amended 13d Rehabilitative Services, as respite services are likely more habilitative in nature.

1915(b)(3) Authority

States utilizing a 1915(b) waiver to implement a managed care program may be able to utilize savings under the waiver cost effectiveness test to fund additional services such as respite care. The populations targeted for the additional services must receive their services through the 1915(b) waiver as the services are funded by waiver savings. The authority is found in section 1915(b)(3) of the Social Security Act (SSA).

Pros	Cons
Opportunity to streamline implementation with existing efforts to modify Section 13d of the current 1915(b) waiver.	Requires a waiver amendment and updates to cost effectiveness calculations
Authority within capitated managed care contracts allows states to mandate access and implementation requirements for respite care.	Funding for the service is limited to waiver savings demonstrated through cost effectiveness.
States can target (b)(3) services to identified participants of the larger 1915(b) waiver	Only populations receiving services under the 1915(b) waiver can receive the (b)(3) service. FFS populations cannot be reached with this authority.
Modifications to the 1915(b) waiver follow a 90-day review process which would allow timely approval.	If under 1915(b)(3), network adequacy and state-wideness standards would apply and may be difficult to meet.

1915(i) State Plan Amendment

States may offer benefits to a specific age group or individuals with specific needs without regard to comparability of services for those who do not receive the 1915(i) services. This includes special services for those who have developmental disabilities, physical disabilities, mental illness, or substance use disorders.

Pros	Cons
Allows the state to identify specific populations and services under the State Plan through a State Plan Amendment (SPA).	While states may ignore comparability requirements, they must provide services under a 1915(i) SPA statewide.
Adding respite as a State Plan service allows both FFS and managed care enrollees to get the service.	The 1915(b) waiver would still need to be modified to include respite care in managed care.
Washington may be able to leverage an existing 1915(i) SPA under development if the populations align.	1915(i) requires the State Medicaid Agency to maintain direct oversight on eligibility determinations and quality oversight measures, while at the same time adhering to all managed care rules.
1915(i) fits well for more habilitative, as opposed to rehabilitative, services.	Would require additional staffing resources at the HCA level to both implement and oversee.

In Lieu of Services

States with managed care programs can develop in lieu of services which are state defined alternative services that are medically appropriate, cost-effective substitutes for state plan services. As part of Community Supports, respite services have recently been approved as in lieu of services by CMS in California.

“Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service, 2) Members are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the managed care plan contracts.”[2]

[2] https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Pros	Cons
Recently approved methodology in other states	In Lieu of authority does not obligate an MCO to offer the service nor require enrollees to utilize the services. May not meet the proviso requirements
Service is considered a cost-effective alternative; may not result in changes to capitation rates though the state may need to demonstrate a financial analysis for CMS.	In lieu of services may only be provided to individuals covered under the 1915(b) waiver. Not accessible to individuals in FFS.
Relatively quick pathway to approval as part of managed care contract.	Would need evidence of cost effectiveness.

1115 Waiver

Washington currently has a comprehensive 1115 waiver which could be amended to include respite services as a benefit allowing the state to include the services under managed care. Examples of implementation include New Mexico and Delaware.

Pros	Cons
Flexibility in delivery including treating the service as a “hypothetical” state plan service allowing the state to include the cost for the service on both sides of the budget neutrality test.	Would require Washington to add the service to its existing 1115 waiver through an amendment. This could be more complicated as the State just posted its 1115 waiver renewal application for public comment.
Could be offered under both managed care and FFS.	This requires a long timeline for implementation and can only be implemented prospectively upon CMS approval.
May allow the state to define the parameters around respite eligibility that may be more flexible than the requirements under the 1915(i) SPA or 1915(c) waiver authority.	Administrative effort to amend the 1115 waiver may be overly burdensome considering the single service.

C-Waiver

Allows states to offer intensive community-based services comparable to an institutional level of care to people who require long-term services and supports. Respite services are currently offered within the State of Washington under Individual and Family Services, Core, Children’s Intensive In-Home Behavioral Support, and Basic Plus Waivers. While there may be an opportunity to provide BH respite care via an existing c-waiver, that avenue would not meet the State requirements to allow broad availability under managed care.

Pros	Cons
Common implementation pathway for States as part of a larger home- and community-based services (HCBS) benefit package.	May not align with targeted population for respite services in Washington (covered via 1915(b) authority).
Allows the state to offer the service to FFS populations.	Covered populations in 1915(c) waivers must meet the state's nursing home, hospital, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) levels of care.
Potential for additional HCBS match though would need to confirm.	Must have case management as part of a 1915(c) benefit package.
	Must be aligned with a 1915(b) waiver to offer in managed care.

Disclosures and Limitations

This report is intended to support HCA efforts to respond to a Legislative request to assess implementation options for BH respite. This report is intended to be relied upon solely by HCA and other Washington State agencies and is not intended to be distributed broadly. Mercer understands that the State may share this report with primary stakeholders to advance policy discussions within the context of the Legislative request; Mercer disclaims any use beyond the intended purpose. The illustrations and examples presented in this report are based on publicly available information, discussions with HCA, and Mercer's experience in other state programs. Information in this report is compiled to provide information for use in determining potential avenues to administer BH respite within the State. Information included in this report is based on direction from HCA and includes discussion of authorities identified as of the date noted in the report. Additional authority options may exist.

The State understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Appendix: Authorities and Key Features

Authorities	Key Features	Benefits	Populations
1915(b)(3)	Waiver. An option available to states implementing managed care through a 1915(b) waiver. States may use waiver "savings" from the cost-effectiveness test to fund additional services.	States identify specific service(s) to offer to populations or subsets of populations enrolled in managed care under the waiver.	States have flexibility to describe services to be offered but must seek approval from CMS as part of the waiver approval process.
1915(i)	State Plan Authority. States may offer benefits to a specific age group without regard to comparability of services for those who do not receive the 1915(i) services, although they must abide by the state-wideness. States may: • Target the HCBS benefit to one or more specific populations • Establish separate additional needs-based criteria for individual HCBS • Establish a new Medicaid eligibility group for people who get State Plan HCBS • Define the HCBS included in the benefit, including state-defined and CMS-approved "other services" applicable to the population • Option to allow any or all HCBS to be self-directed	States typically offer a combination of acute-care medical services (e.g., dental services, skilled nursing services) and long-term services (e.g., respite, case management, supported employment, and environmental modifications) in home- and community-based settings.	Allows states to target people with specific needs, including special services for those who have developmental disabilities, physical disabilities, mental illness, or substance use disorders.
In Lieu of Services	Managed Care Contract. States may identify services that are medically appropriate, cost-effective substitutes for state plan services. Enrollees cannot be forced to utilize the services and managed care organizations cannot be required to offer the services.	States have flexibility but must identify in lieu of services in the managed care contract. Benefits are priced at their cost and included in rate setting.	States have flexibility to limit populations eligible for the services to be offered

Authorities	Key Features	Benefits	Populations
1115	Waiver. Broad authority allowing states to develop demonstration. Allows waiver of many sections of 1902 of the SSA and can allow for additional services and populations as ”costs not otherwise matchable” funded through waiver savings. Requires state identified populations, services, evaluations, and usually budget neutrality agreements.	States identify specific service(s) to offer to populations or subsets of populations enrolled in managed care under the waiver.	States have flexibility to identify covered populations but must seek approval from CMS as part of the waiver approval process.
1915(c)	Waiver. Allows states to offer intensive community-based services comparable to an institutional level of care to people who require long-term services and supports. Waiver must: • Demonstrate that providing waiver services will not cost more than providing these services in an institution • Ensure the protection of people’s health and welfare • Provide adequate and reasonable provider standards to meet the needs of the target population • Ensure that services follow an individualized and person-centered plan of care	States can offer a variety of unlimited services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services.	The population can be targeted by age or diagnosis, such as autism, epilepsy, cerebral palsy, traumatic brain injury, or HIV/AIDS. Eligible individuals must meet the state’s institutional level of care requirements.