

Community Advocacy Coalition

Problems with Mental Retardation Transformation Project

The Community Advocacy Coalition consists of statewide and grass roots groups of persons with retardation, their families and their advocates. For over a decade, we have strongly and consistently advocated for reform of our state's mental retardation system including the right of self-determination for persons receiving mental retardation under the federal Medicaid waivers.

In November, 2000, the Federal Centers for Medicaid and Medicare Services (CMS) found the Pennsylvania Office for Mental Retardation (OMR) to be non-compliant with Title 19. OMR responded to these findings by initiating the Mental Retardation Transformation Project. (MR TP) Initially this appeared to be a vehicle for enhancing self-determination, improving the quality of supports and for correcting compliance issues.

Over time, as OMR's TP was revealed, it was clear that portions of the TP were inconsistent with these goals and would actually turn back the years of efforts to assist persons with mental retardation to live normal lives in their communities. We have advocated in opposition to those aspects of the MR TP that we consider to be ill-conceived, unnecessarily costly and harmful to persons with retardation.

We have heard many rumors as to what our position is and why. Below is a summary of what we consider to be the main problems with the MR TP. It is our desire to be part of the solution and we stand ready to work with DPW to that end.

A. Consumer Control over Budgets will NOT Create Choice

1. OMR's Budget (IER) is Cost Containment, not Consumer Empowerment, because:

- a. It precedes service planning.
 - b. It violates guarantees in the Medicaid waiver when inadequate budgets deny needed services.
 - c. It fails to recognize differences in service configurations. One budget will be too small for most consumers, but a windfall for others.
 - d. It uses old costs and the costs of different service configurations. Most budgets would therefore be too small to finance need.
 - e. It can be manipulated as easily as the present system, thereby not guaranteeing a more equitable system.
 - f. It is over-reliant on an unworkable appeal system to fix the errors inherent in the budget process.
 - g. Individual budgets already exist for most consumers, and can easily be developed for the remaining consumers.
 - h. The draft ISO Bulletin (a necessary component to implement self-determination) is a theoretical document which is confusing, internally inconsistent and raises many implementation problems.
 - i. The draft service definitions are overly medical and will result in persons being terminated from services, particularly low-cost supports.
2. The MR TP does not encourage consumers and families, or require counties and providers, to make the issue of integration paramount in all program planning. (A more detailed discussion of the issues surrounding the successful implementation of integration and consumer choice will be provided in a forthcoming position paper.)
 3. The MR TP does not address the real obstacle to choice.
 - a. Pennsylvania's mental retardation system has relied historically on 3-person group homes as the primary community-based model for consumers who do not live with their families.
 - b. Giving consumers control over budgets worth one-third of a 3-person group home does not create choice.

- 1) If the consumer chooses an existing group home vacancy, family living, or supported living, what happens to the two remaining consumers now living in a 3-person group home that has funding for only 2 people?
 - 2) If the consumer wants a new group home developed by a new provider, where does the funding come from for the other two roommates?
- c. Implementing choice will usually involve several complex, inter-dependent consumer moves that require:
- 1) Identification of persons who desire to exercise choice;
 - 2) Identification of persons for whom a move to a more integrated option would be desirable, as part of the service planning process;
 - 3) On-going tracking of all vacancies, potential vacancies or new service opportunities;
 - 4) Recognition that the “choice” of one consumer may affect the choice of other consumers;
 - 5) Addressing County/Provider (System) financial risk which results from choice; and,
 - 6) Intense cooperation among consumers, families, providers, and county staff.
- (These issues are discussed in greater detail in the forthcoming position on Integration and Choice)

B. A fee-for-service payment system is dangerous for Pennsylvanians with mental retardation.

1. Medicaid requires states to adopt consistent (statewide) payment methodologies, but does NOT require a fee-for-service system.
2. Fee-for-service payment is the antithesis of person-centered, individually-based planning.

3. Fee-for-service payment is based on the assumption that all services are the same, are inter-changeable, and can be mass-produced.
4. In tough economic times, state budget writers will cut, freeze, or otherwise “contain” these fees, putting client services at risk.
5. Statewide fee-for-service payment empowers the state to manage costs at the expense of client services.
6. A fee-for-service payment system will eliminate the legislatively authorized quarterly cash advance system, thereby increasing system-wide costs putting provider financial stability at risk and therefore limiting service to consumers.
7. The existing system is cost-effective because:
 - a. there are limits on overhead (administrative cost caps);
 - b. There are limits on retained earnings (3%); and,
 - c. There are limits on executive salary reimbursement.
8. The MR TP promise to providers that they will be guaranteed retained revenue up to 3% each year, will provide a powerful financial incentive for providers to find ways to reduce services. This revised policy will also reduce funding now being utilized by counties to meet increasing needs of existing consumers or to meet emergency needs.

C. The MR TP actually proposes a radical transfer of powers from county to state government that requires authorization by the Legislature (amending the 1966 MH/MR Act).

1. The Powers transferred from County to State Government include:
 - a. Control over consumer budgets;
 - b. Billing and payment (using MAMIS);
 - c. Web-based medical records (HCSIS); and,
 - d. Adjustment for changing consumer needs.

2. Shifting administrative responsibility from County to State Government is nothing more than going from the frying pan to the fire; replacing a local bureaucracy with an expanded, more removed state bureaucracy.
- D. OMR is attempting to implement significant changes in Pennsylvania's mental retardation system BEFORE the required adoption of new or amended regulations.
1. The 4300 Fiscal Regulations cannot be amended by Bulletin.
 2. Provider participation in HCSIS can only be directed by regulation.
 3. The "ITQ" process must be implemented by regulation if not by legislation.
- E. OMR has not presented a convincing cost/benefit analysis to support the full implementation of HCSIS (except for Incident Reporting).
1. What is the full (past, present, and future) cost to the state of HCSIS?
 2. Why isn't OMR paying the increased local costs of entering consumer medical records into HCSIS?
 3. Won't consumers be short-changed as caseworker resources are shifted to time-consuming data entry?
 4. Why didn't OMR provide counties and providers with cost-effective software to support their own electronic medical record keeping systems, instead of developing one slow and expensive statewide system?
 5. What does OMR intend to do with the data in HCSIS and how much will that cost?
 6. Why hasn't OMR utilized the regulatory system to ensure a public debate over these issues and to ensure the validity of statewide data by requiring that all providers utilize this system?
- F. The "Invitation to Qualify" (ITQ) process will not assist in creating consumer choice.
1. If the ITQ process is designed to force County MH/MR Administrators to contract with Qualified Providers chosen by

consumers/families, it would be easier and cheaper to add such a provision in the annual Medicaid Waiver contract between OMR and the Counties.

2. If the ITQ process is designed to improve the quality of provider services, then licensing standards should be amended through the regulatory process.

- G. An example of why choice does not work today and why the MR TP does not fix the problem:

A person living in the 3-person group home wishes to move to family living. His parents support this move. The individual's group-home budget is known and the family living program will cost about half as much (no IER issue). A family living provider has accepted the consumer and that provider already contracts with that County (no ITQ problem). The County nonetheless resists the move because if the consumer moves, the County will need to spend additional money supporting the 3-person group home unless alternatives can be found for the two remaining consumers or additional funding can be found for a third person to move into the group home. The MR TP does not solve this problem.

- H. MR TP promises everything to everyone: Where is all this money coming from?

1. It promises control over budgets and choice to consumers/families.
2. It promises better reimbursement to providers.
3. It promises better management of costs to state budget writers.
4. It neither delivers on these promises nor addresses the issues raised by CMS.