Base Service Units
In Relation to MH/MR Act and Chapter 4210 Regulations

A Pennsylvania Community Providers Association
Issues and Research Paper

Background

The Office of Mental Retardation's final bulletin on "Revision of Definition of Conflict Free Providers for Targeted Service Management" presents problems for PCPA members who have traditionally provided both case management and MR services and supports. There will also be problems for consumers who are used to receiving their case management and other services from one provider. The consumers in rural areas will be at a disadvantage during the transition when service providers are being developed to take on either the supports coordination or service provider roles.

The current system of Base Service Units (BSUs) has worked in many areas of the state since the inception of the 1966 MH/MR Act. The change is being forced due to the Office of Mental Retardation's (OMR's) interpretation of federal Medicaid waiver requirements for consumer choice of provider and case manager/supports coordinator.

The question has been raised as to whether the new Conflict Free Targeted Services Management Bulletin conflicts with the MH/MR Act and Chapter 4210 Regulations. We have reviewed both documents and present our findings here. This is not a legal opinion. If such is desired, we recommend that providers consult their agency attorneys.

Review of Law and Regulations

The *MH/MR Act of 1966* contains no reference to Base Service Units (BSUs). The Act places the responsibility on the Counties to "establish a county mental health and mental retardation program for the prevention of mental disability, and for the diagnosis, care, treatment, rehabilitation and detention of the mentally disabled", as stated in Article III, Section 301 (a). A list of services to be provided is listed in 301 (d) but only services are listed, not the method of providing them. Section 301 (f) gives the counties latitude in service provision: "Services herein required or authorized may be provided either directly or by purchase of such services, except that the services required in Section 301 (d)

(9) shall be provided directly through the county administrator." The services referred to in Section 301 (d) (9) are unified intake procedures and a central place that provides referral services and information.

The *4210 Regulations*, that clarify and implement the 1966 MH/MR Act, specify the range of services that must be provided or arranged by the county MH/MR Program. Patient Services are described in 4210.21. The county administrator is given the responsibility, through the use of a base service unit, for the following: continuity of care for patients, and maintenance of a relationship with the patient and a facility or service provider, from intake to closure. The BSU, then, is to facilitate and coordinate the patient's movement from service to service.

The basic functions of a BSU are listed in 4210.22. These functions include an intake study and recommendations to the administrator or appropriate referrals; development of comprehensive treatment programs; coordination of services and responsibility for continuity of the treatment program; assurance that there is collaborative planning for people in State facilities; furnishing "as much treatment services as feasible on its own initiative or at the request of a provider of service"; and maintenance of central files for each person in its area.

This description of functions does not indicate that BSUs must provide the treatment services. It can be interpreted that treatment program development is akin to the development of what is now called an Individual Service Plan or Individual Support Plan.

In Section 4210.23, the BSU is required to coordinate the services of resources that are "not under the direct jurisdiction of the local authorities". A liaison function is described here, but not a treatment function.

The composition of Base Service Units is addressed in 4210.25 (a), which states in part: "The composition of base service units shall be subject to the Department's review and approval". This gives DPW the opportunity to determine which professional and nonprofessional staff should be working at BSUs. "Treatment plan" is referred to again in 4210.25 (c) but there is no mention of actual treatment.

Under "Methods of providing base service units", Section 4210.26, the local authorities are given the right to contract with a community MH or MR center that can staff a BSU or to contract with other resources who can complete the staffing of a BSU. It is clear that BSUs may be staffed in part or in full by personnel directly on the staff of the county administrator and that local authorities may contract for supplemental services required by BSUs.

The services listed in the Act are defined and described in the regulations. The BSU is referred to in the section on Outpatient Services. In 4210.52, it states that: "Outpatient services may be furnished under the county program by the Base service unit, by community mental health and mental retardation centers, by community clinics or by clinics conducted by hospitals or by institutions for persons with a mental disability." The regulation goes on to state that licensing is required for outpatient services. Note that the word "may" is used in 4210.52, rather than the word "must".

Within these regulatory service descriptions, BSUs are mentioned again in Rehabilitative and Training Services - 4210.72, Aftercare - 4210.81, and Interim Care - 4210.95. The Rehabilitation services are to be arranged by the BSU when they cannot be provided by other departments' funding sources. There is nothing in these sections of the regulations that says the BSU should or must provide the Rehabilitation services. Aftercare services consist of "services prescribed by a base service unit" but there is no requirement (or even mention) that the BSU be the provider of the services. The Interim Care section requires BSUs to monitor people in interim care when they are waiting for institutional care and to arrange for alternative resources, when appropriate.

Intake Procedures, 4210.101, are described as being the responsibility of the BSU. Within this responsibility is treatment recommendation with development of a service plan. Part (c) refers to a procedure for informing the administrator that intake and planning has occurred, "if service is to be provided by the base service unit". There is no requirement that a BSU offer treatment, although this section describes the possibility that BSUs might provide treatment.

The county program's responsibility for the program and services evaluation is found in 4210.182. This responsibility is shared with the Board and gives the County the responsibility to analyze and evaluate MH and MR needs and to recommend improvements. This section seems to give county programs the right to change their systems to meet their needs.

<u>Review of Current Practice</u>

In an effort to document current practices in the Commonwealth, PCPA undertook a quick review of management practices in relationship to the Base Service Unit concept. There are three methods of managing the Base Service Unit functions: (1) In what had been the "traditional" model, these functions/services were contracted to provider agencies, often due to the 1960's establishment of federal Community MH/MR Centers that had both intake and service capacity. (2) In several counties, independent non-profit entities have been established to serve as the Base Service Unit. (3) In other

counties/joinders, the County has direct responsibility for the operation of Base Service Units.

Our review indicated that nearly 45% of the counties (21 joinders with 30 counties) managed the services directly. Four (4) or about 6% had been moved by their joinders to independent non-profits. About 42% (17 joinders with 28 counties) of the Base Service Units were managed through contracts with Provider agencies. It should be noted that PCPA did not confirm the management style in 4 (8.7%) of the counties. One of these four is in transition from a provider contract model to an independent non-profit model. Preliminary indicators however, show that many of those programs were also county managed. Table 1 presents this information for both Counties and for combined County (Joinder) programs.

Location of Control - BSU's

	Counties		**Joinders**	
	#	**%**	**#**	**%**
County Run	30	44.78%	21	45.65%
Independent Non-Profit	4	5.97%	4	8.70%
Provider Run	28	41.79%	17	36.96%
Undetermined	5	7.46%	4	8.70%
Total	**67**	**100.00%**	**46**	**100.00%**

Table 1: Location of control (management) for Base Service Units in Pennsylvania Counties

In summary, practice patterns indicate that a diversity of models exist, with a nearly equal split between BSUs that are independent non-profits with county management and those that are run by providers.

Issues and Conclusions

Our review of the Base Service Unit regulations found that the county and state do have the right and ability to make changes in service planning and delivery, as they deem necessary, to meet the needs of people served and to meet the needs of the overall MH and MR system. The Office of Mental Retardation's Bulletin titled "Revision of Definition of Conflict Free Providers for Targeted Service Management" appears to be within the parameters of the 4200 regulations and the MH/MR Act.

Our research found that the MH/MR Act and the 4200 Regulations do not require that Base Service Units provide MR services and supports. As past practice

illustrates, they certainly do allow this to occur. There is no mention of the need to be a "conflict free entity" in Pennsylvania law or regulation, or in the Targeted Case Management description in the State Medicaid Plan. It could be inferred that the Office of Mental Retardation has changed regulations by issuing the "Conflict Free" bulletin, without pursuing the regulatory change process.

Base service units that have been providing both MR case management and MR services have provided integrated services in a "one stop shop", making it simpler for consumers to get what they need. The expertise of the BSUs has benefited consumers and has created efficiencies that would be helpful to consumers in the changes being wrought by the Transformation Process. Documentation of negative results of the system of combined services and case management has not been presented by OMR. Nor has OMR, to our knowledge, considered ways that the purported conflicts of interest could be alternatively managed in a manner that would allow agencies to provide both services and Supports Coordination.

As PCPA has stated in other documents and position papers, there will always be some conflict when there is a funding source that controls services. To quote from our November, 2001 letter to OMR: "Even a free standing Targeted Service Management (TSM) agency would have conflicts with the county, its direct funder. If a Supports Coordinator at a TSM agency knew that the county did not have funds for a service needed by a consumer, s/he could be pressured to keep that service out of the Individual Service Plan. This conflict will surely arise under the proposed Bulletin. A county MH/MR office that provides TSM will have an even sharper conflict due to the tug and pull of sometimes inadequate allocations versus meeting the true needs of consumers. A county in this position could not truly advocate for the consumer and family."

The Waiver review in 2000 by the Health Care Financing Administration/Centers for Medicaid and Medicare Services (CMS) states on page 10: "A services manager who is under the control of the county is only 'conflict-free' from the point of view of the county." The report goes on to say that the Commonwealth must take action to allow waiver consumers to exercise the choice of independent service managers and describes what each county/joinder, or larger geographic area, must do to make this available. After the HCFA/CMS report was issued, OMR pulled Supports Coordination out of the waiver, though it is still funded through Medicaid.

The OMR definition of "conflict free" was finalized with publication of the bulletin in April 2002. CMS is scheduled to review the Person Family Directed Services waiver in the fall of 2002 and may still see a conflict between the Medicaid requirement for consumer choice and the current "Conflict Free" Bulletin.

In Pennsylvania's Medicaid State Plan, a section on Targeted Case Management Services for Persons with Mental Retardation defines case management services. There is no language that implies "conflict free" when "Freedom of Choice" is addressed. The Department of Public Welfare assures CMS "there will be no restriction of freedom of choice, in violation of Section 1902 (a) (23)." To quote from the document:

"Each recipient shall be:

1. informed of the service alternatives available to the recipient.
2. given the opportunity to choose between available providers of case management services.
3. given the opportunity to choose among available case managers.
4. given the opportunity to choose between available providers of service.

Freedom of choice requirements will be established as a condition of provider participation in the Grant Agreement between the Department and the County MH/MR Program and will be monitored by the County MH/MR Program and the Department."

As stated previously, this addresses freedom of choice of case managers by consumers but there is no mention of conflict in a provider agency or BSU.

In another section of the Medicaid State Plan, titled Providers of Service, the Case Management Unit (CMU) is defined. The authority to "establish, direct, control, and monitor the activities of the CMU in accordance with the MH/MR Act of 1966" is given to the County MH/MR Administrator. It also states: "The CMU shall be 1) a free-standing single-purpose agency, 2) a part of a larger, multi-purpose agency having a separate, clearly definable organizational unit function as the CMU, or 3) an organizational unit within the County Mental Health and Mental Retardation Program." There is no mention of a need for CMUs to be conflict free.

There is widespread agreement among stakeholders that the supports coordination (or targeted case/service management) function is key to fully serving eligible consumers under the waiver. The Supports Coordinators should be free of the county fiscal and budget functions in order to fully define and advocate for consumers' needs in this waiver entitlement program. They should be able to advocate for consumers' needs and to make recommendations for fully serving them through the Individual Support Plans, without being pressured by county government to cut individual costs. The supports coordination function should be fully supported by all funding sources. Caseload ratios are high at the 50:1 approved in the Medicaid Plan. Without sufficient funding and smaller caseloads for Supports Coordinators, the Person Family Directed Supports waiver will stand on a weak foundation.

The Office of Mental Retardation, through the April 2002 Bulletin, requires that those who want to provide Targeted Service Management support coordination services be conflict free (interpreted as providing either support coordination *or* services) by July 1, 2005. It is our understanding that Philadelphia County, and perhaps other counties, want to make this change by July 1, 2004. Although we disagree with the Bulletin, its deadline of July 1, 2005 will at least give organizations more time to make appropriate changes within their corporate structures and with consumers and families.

Another issue that needs to be addressed is whether OMR will accept the creation of a new organizational entity by an existing Base Service Unit (or by any other provider of both services and supports coordination) for provision of either the services or the supports coordination function. Corporate models that appropriately avoid conflict need to be defined and designed. A County MH/MR Program that chooses to use an existing provider of both services and supports coordination needs to know how it can adapt to the new bulletin and the definition of "conflict free".

In summary, although our research shows that the PA MH/MR Act and 4200 Regulations do not require that BSUs provide both supports coordination and services, they do allow it and the approach has been successfully used for three decades throughout the state. There may still be conflicts between Medicaid law and the Conflict Free bulletin that will have to be worked out through waiver reviews and through any challenges presented to OMR by those who strongly disagree with the new Bulletin. Additional discussion of conflict free 'distance' between an entity's possible separate corporations for service and supports coordination is needed.

Future regulations that deal with the issue of conflict in this context will need to address both state and federal requirements, since Medicaid is now the primary funding source for Pennsylvania's MR system of services and supports. It is anticipated that broad stakeholder input will be utilized for formulation of such regulations. It is hoped that consumers will not be harmed when they are forced to leave either their supports coordinators, who often know them well, or their long time providers who are the source of their daily services and supports.