From a Provider Centered System to A Participant Directed Person Centered System of Services and Supports for Citizens with Significant Disabilities in Kansas: An Analysis of Multiple Funding Structures

By

Stephen R. Hall PhD

Director Employment Research and Development

Griffin Hammis Associates

September 2015

Note: During the final week in preparing this analysis, CMS announced major changes to funding employment supports and services, ***highlighting self-direction options for employment support.*** An analysis of these very latest changes is included. An ***** will appear near any piece of analysis throughout that is an issue being potentially exacerbated by the CMS changes or an issue that is being resolved and is in significant agreement with the just announced CMS changes.

Introduction

This is:

- An analysis of multiple funding and support structures, in particular self-directed employment services;
- With the specific purpose to increase provider capacity;
- To ensure a high quality workforce with low staff turnover;
- To create a seamless transition from school to integrated community employment;
- To transition adults from facility-based services to integrated employment in a steady pragmatic manner, and;
- To increase access to paid-work experiences, training, and internships such as Project Search.

The numbers of persons with developmental disabilities, behavioral health, physical disabilities, head injuries, and other disabilities in Kansas and across the nation varies with data interpretation. For the purposes of this analysis of multiple funding structures, we are choosing to only speak about citizens with intellectual or developmental disabilities, and to some degree citizens with behavioral health needs. This does not mean that the information has little merit for citizens with other disabilities. In fact, one of the very first government sponsored self-direction efforts was the Cash and Counseling initiative meant primarily for persons with physical disabilities wanting more choice and control over who would be paid to assist him or her with personal services. Most persons who self-direct services in the United States today are persons with physical disabilities (Reinhard, S., Kassner, and others, 2011, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Disabilities, and Family Caregivers.)* Self-directed supports and services are possible for every Kansan with a disability considering this analysis.

About 321.3 million persons live in the United States. In the most conservative estimate less than 1% have a developmental disability (.78%), about 2.5 million people. Of these 2.5 million persons, about 40% receive formal services and supports funded via a government agencies' funding. Kansas has about 1.8 million residents of working age, between 18 and 65 years of age, with .78% or 13,817 adults with intellectual or developmental disabilities. About, 6600 of these citizens receive government funded services and supports, mostly through a Medicaid waiver.

In America, people are free to purchase or not purchase from various providers of goods or services. This is a typical way of doing business in countries that are considered free democracies. In democracies, citizens have many choices of where to buy goods or services, in some other forms of government people have few, limited, or one "choice." This analysis is to make the system of supports and services in Kansas--more American--with more freedom of choice to ensure citizens

with disabilities in the Sunflower State have more options, provider choices, for the employment services and supports they need.

Participant-directed services

The best information on Self-directing Medicaid Services is the National Council on Disabilities (2013) *The Case for Medicaid Self-Direction: A White Paper on Research, Practice, and Policy Opportunities*. Self directed service began with the Robert Wood Johnson Initiatives, the Medicaid Independence Plus Grants to 11 States between 2002 and 2004, and the additional 12 states that were awarded the Real Choice System Change grants. In 2014 the Centers for Medicare and Medicaid Services said in the new Medicaid Final Rule in regards to self-directed services: "We believe it is fundamental for individuals to have control to make their own choices."

There are some persons in some parts of the United States, not Kansas, who would disagree with the National Council on Disabilities White Paper, seek to limit participant direction of services, and have worked to ensure it is not an integral part of the supports and services offered via Medicaid waivers. Their charges have claimed that parents are hiring strangers that may be harmful via self-directed services, that they already have self-direction because nobody is forcing anyone to pick a particular provider for his or her services, and that it is just a scheme for parents to pay themselves.

All of these contentions have proven untrue when states follow CMS published and recommended technical guidelines for implementation of participant directed services. Without specific guidelines to ensure quality implementation of participant directed services in accord with CMS technical guidance, self-directed services, like anything done poorly and out of compliance, does have the potential to be abused. But, most, including long-standing providers of services, see quickly that participant-directed services are a higher quality way to deliver better services to

persons with disabilities. It allows providers to receive full payment for services based on payment for services rendered as promised.

The four essential components of effective participant directed services are:

1. A universal assessment of need to ensure funding is allocated fairly to the person's individual budget with the assurance that others similarly situated will have similar budgets. Those with greater assessed needs will have larger allocations and those with less assessed needs will have smaller allocations. The allocation of the taxpayer funds must not be firmly tied to historic service use, but to the person's needs relative to others with similar needs.

2. A Conflict-free Case Manager* that is not employed by an agency that also provides services. This Case Manager ensures the services that he or she has written and authorized in the individual plan of services are being implemented to the degree and extent promised. The Case Manager's role is to first write and approve of the person's annual individual plan of services, then to monitor the delivery of those services to ensure they are delivered on time and in a quality manner.

   As needed, the Case Manager will amend the plan throughout the year, to ensure the providers of the varied services are delivering those services in an effective manner. The Case Manager authorizes changes in providers if the current providers of services are found less effective than anticipated or promised.

3. A Community Guide (supports broker) is hired by the participant to assist the person with disabilities to locate services, other resources, and people in the community to help implement the individual plan. Persons must have the skills and be qualified to implement the needed services and supports.

Historically disability providers authorized by the State have been the employers of such persons, but the person self-directing services is not limited to only choosing from among traditional providers of services.

The Community Guide's role is significantly different from the Case Manager who writes, oversees implementation, monitors, amends, and ensures quality of the plan. The Community Guide creates the person's individual budget after meeting with potential providers of services while acting on the person's behalf as a services support broker, arranges for the specific duration, intensity, and type of services. The Community Guide returns to assist as requested by the participant of services, often receiving the same utilization reports received by the participant, and to help communicate with the chosen providers of services upon request.

4. A Financial Management Service or fiscal intermediary is hired by the State Medicaid office to collect employment taxes and to pay providers of services who do not have an assigned Medicaid vendor number. Use of a Financial Management Service allows providers of discrete services to be paid for delivering uncustomary habilitation and rehabilitative employment services. These services could include payment to a provider who is teaching and training a person an employment skill as authorized in the person's individual plan of services, usually the person's employer.

To augment the four essential components mentioned above, there are supplemental quality protections that optimize the effectiveness of participant directed services:

1. In addition to the allocation of the individual budget based on assessed need, the provider rates must be based on the provider's exact state allowed costs, individual provider rates based on ***a state's transparent allowable formula****, instead of a statewide rate that does not account for differential

employee pay. This makes it clear that provider's will be fairly paid for the services they render and that a significant amount of the payment to providers will be the wages of those who provide the direct services. Individually-determined provider rates based on state allowed costs* eliminates revenue that may be gleaned via low pay, excessive staff turnover that reduces the providers' financial outlay, grouping people in attempt at economy of scale savings, excessive administrative overhead, etc. Most importantly, it gives providers the revenue to pay those who provide direct services well, to pay benefits, to reduce staff turnover, to encourage and pay for inservice education and training—all essential to improving the quality of service outcomes.

2. A choice from among four different types of providers is critical to ensure real participant directed choice:
   a) Traditional Habilitation/Rehabilitation providers who have customarily and ordinarily provided facility services including transportation to and from sheltered workshop services, day centers, group homes, work crews and work enclaves, and additionally individual supported employment services.
   b) Traditional Employment and Community-only non-facility service providers. These are providers that have been providing habilitation and rehabilitation employment and community participation services, some for the past 30 years, as an alternative to persons attending a facility.
   c) Non-traditional providers who provide services to 1-3 people, who meet requirements for providers of similar services as required by the state, are certified, but not accredited to the extent required of small, medium, and large traditional providers of services. These providers do not have an assigned Medicaid vendor number, using the Medicaid contracted Financial Management Services agency to receive payment.
   d) Non-traditional discrete skilled service providers, such as the participant's employer, who can deliver very specific habilitation and

rehabilitation services and training necessary for the participant to become fully employed at a living wage, and these providers do not have a Medicaid vendor number and would use the Financial Management agency's services.

An analysis of multiple funding and support structures, in particular self-directed employment services

The alternative funding mechanism most touted to States is the Milestones/Tiered Payments Plan and is being supported by the current federal Employment First Initiative through the Office of Disability Employment Policy*. An analysis of this funding methodology will follow this listing of its key components:

1. Payment to providers only after a pre-designated accomplishment, a milestone, has been achieved. This is to incentivize outcomes and not service delivery.
2. An expectation that funding will be faded is built into all system reimbursements. This is to encourage beneficial outcomes.
3. Payment to providers for on the job supports is directly tied to outcomes such as hours worked. This means that the more hours the person works then, all things being equal, the more the provider will be paid.
4. The payment to providers is determined by a combination of the length of time the person has been on the job, the person's pre-determined level of disability or challenge, and the amount of hours the persons is working.
5. The payments received by the providers of services are rebalanced based on staffing ratios. This means that the amount of payment the provider receives is lessened if the service is delivered to a group of people with disabilities.
6. The payments for community based wrap-around supports, such as community participation and community access services are developed separate from the manner reimbursement is determined for employment services.

An analysis of the milestone/tiered payment structure

For at least the past 15 years, most states have been given the advice to adopt Milestone or pay for performance payment methodology through Vocational Rehabilitation followed by tiered payment systems based on level of need and hours worked on the ongoing follow-along and support services side, usually funded by a long terms supports and services state agency such as Developmental Disabilities.

Prior to 2001, since the beginning of Supported Employment in the mid-1980s, and throughout the 1990s, the widespread reimbursement methodology was an hourly fee for services rate, for both Vocational Rehabilitation and the long-term support agency. In some instances these hourly rates were individually determined based on the provider's exact costs, and the hourly rate was the same for Vocational Rehabilitation and the long term support and follow along state agency. This sameness was the desire to create a neutral funding mechanism that didn't incentivize the provider to jump from or remain inordinately on the Vocational Rehabilitation funding. This way of funding services let the rehabilitation activity itself, the person's need; determine the source of funding without incentivizing the provider to bill more hours. Since the rates all varied for the exact same service and were based on each providers exact costs, there was no profit to be gained by billing more hours.

When the person's need for support was lessened to approximately 20% of the person's time employed, the source of funding was transferred from Vocational Rehabilitation to the long-term funding and support agency. This way of funding services was changed in about 2001, as the adoption of milestone payments became widespread.

Milestone payments were touted as the wave of the future, just as they are today*****, and many state Vocational Rehabilitation agencies adopted this pay for performance funding methodology. The results have been a continuous decline in the number of

citizens who've received a job via supported employment in the community, reducing Vocational Rehabilitation and the long-term support agencies financial investment in Supported Employment by one-half (Braddock, 2015).

The problem is simple: Vocational Rehabilitation costs for Supported Employment were about $7000 to $10,000 in the hourly fee for service funding mechanism. Since adopting the milestone methodology the Vocational Rehabilitation investment is about half that amount, $4500 at most in Kansas. Then and now, providers get paid nothing no matter how much work they do or services provided if the milestone is not achieved successfully.*****

Milestone Payment Methodology compared to Hourly Payment Methodology

1. Milestone payment to providers is given only after a pre-designated outcome or milestone has been achieved. In Kansas, usually three or four payments totaling $3500, with $1000 average additionally approved upon the provider's request for job coaching. Even milestone payment adherents agree, this way of funding services incentivizes providers to only serve persons with less disabilities, less than the number of persons eligible for VR services under WIOA.
2. With the milestone payment plan, the provider begins losing money immediately as payment is given only after success, not for services rendered. The provider must pay salaries and administrative expenses usually over several months in hopes of the result being a successful outcome. The provider gets paid nothing for any work performed if the milestone outcome is not reached, even if circumstances beyond his or her control prevents the accomplishment of a pre-designated milestone.*****
3. Under the best circumstances, little more than two of three persons who have never worked in a competitive community job will succeed in that job on the first attempt no matter the payment methodology, meaning providers are on the hook without a VR payment for one out of every three persons

they try to achieve successful community employment for within the community. In Kansas the milestone payment methodology has been successful in securing successful employment (VR Status 26) of citizens with developmental disabilities less than half of the time.

4. With milestone payments, the number of hours the participant works is incentivized to be as small as possible; to lessen the on-site training and support cost outlay. From a fiscal point of view, milestone pay for performance payments encourage providers to only work with persons who are higher functioning, the most capable, with the fewest challenges and disabilities, and for him or her to work the fewest hours possible to minimize provider expenses.*****
5. In contrast, the hourly fee for service funding mechanism ensures the provider will be paid the exact costs to provide services to the participant by his or her provider agency. Vocational Rehabilitation routinely determines what is an acceptable amount of hours to pay the provider for the services rendered. For example, someone getting a job through supported or customized employment will routinely need between 30-70 hours for the up front job development/Discovery phase to ensure a successful and lasting employment match. During job site training phase of job coaching, it is routine for the persons to need between 100 and 250 hours of employer/worksite systematic instruction job training and the successful fading of support. Ongoing follow-along and support services are typically paid for by the state long term support agency, from 50 to 100 hours per year, depending on the persons ongoing support needs. Simply put, the usual one time costs are substantial for the Vocational Rehabilitation job development and job site training phases, and less costly annually, throughout the person's lifetime, on the ongoing support and follow along phases of customized and supported employment.

6. The milestone/tiered system has the expectation that funding will be faded and this expectation is built into all reimbursements, VR and the ongoing

follow-along support services.* While it is true that VR's funding involvement is quickly faded under a milestone payment system, the tiered funding mechanism based on hours worked and the persons level of disability ensures the provider will receive continuous and ongoing payment no matter what the persons ongoing support needs actually turn out to be because payment isn't tied to support needs.*

7. It is routine for someone to be successfully case closed by VR Status 26 and working 24 or more hours per week and to find upon re-examination that this person is working on average but 9 hours per week, eighteen months later. Although in a tiered system the provider's payment is greater if the person works more hours,* at some point minimizing the ongoing support and follow along costs becomes a greater financial incentive to the provider than the few thousand dollars difference the provider may make from ensuring full time employment. Because payment in the tiered payment system is tied to the hours the person works ***and the person's level of disability***, providers are incentivized to recoup the maximum amount of ongoing funding possible with the minimum amount of ongoing support and follow-along costs.* For example, given two people with similar needs, it is likely more lucrative to receive $6500 for ongoing support and follow along for someone who works but 6 hours a week than receiving $9800 for someone who works 40 hours per week .

8. Although point 7 has merit, the most money that can be made by the provider if the person is extraordinarily high functioning, is working full-time 40 hours or more, and needs little ongoing support. Although the payment rate for someone who is high functioning will be less in a tiered funding system, this financial negative is countered by the payment being higher if the persons works more hours. The end result, whether the rate is higher due to more hours or due to the person's more significant disabilities, *the financial savings to taxpayers of someone becoming employed is largely*

*negated by tiered funding of ongoing support** well above the actual costs to provide these services, and the payments to providers are almost always above the costs to provide the services.

9. Truth be told, tiered funding has been really about giving the providers money beyond the costs of services on the backside to make up for dollars lost in the underfunded up front VR-funded portion of the employment process.* CMS changes *in just the past week* have been designed to bring additional accountability to tiered funding by ensuring that any funding system based on the participant's hours worked and any state tiered funding system submitted to CMS must be based on an hourly rate (See added analysis beginning page 24.)*

10. With tiered follow along support funding, payment to providers varies when the payment is directly tied to outcomes such as hours worked. This means that the more hours the person works then, all things being equal, the more the provider will be paid, no matter the amount of services and supports the provider has rendered.* But, this incentivizes placement in jobs that may pay less but offer more hours. And is a disincentive to work in a job that may pay significantly more, but require fewer hours of work. It also likely further encourages placement of persons who are higher functioning.

11. *Adherents* of milestone/tiered follow along payment systems admit, tiered funded follow along support is an attempt to buttress the tendency to cream when using milestone payments, only placing persons who are among the highest functioning in jobs. With the performance or milestone payment funding mechanism providers are financially incentivized to cream to the extent that the provider is financially encouraged to help only persons with the least disabilities and who work the fewest hours. Milestone payments are supposed to deliver lots of quick VR status 26 closures of persons at a relatively low cost, but many providers are discouraged by the lack of enough

money in the beginning to cover costs.* The end result is that those who do end up working often average only 9 hours a week of work at or near minimum wage 18 months after VR closure.

12. The backside support and follow-along tiered payment system that accompanies the upfront milestone payments says this: Providers, if you get people working more hours then we'll pay your more. This likely further exacerbates, instead of resolving, the issue of creaming since it is more likely the provider will choose persons who are most capable in hopes that they can work the most number of hours for the provider to receive greater payment with least need for ongoing support and follow-along costs.

13. With tiered funding the payment to providers is determined by a combination of the length of time the person has been on the job, the person's pre-determined level of disability or challenge, and the amount of hours the persons is working. But the payment to providers being referred to here is not the VR payment to providers. The VR payment in a milestone system is the same no matter how significant the person's disability or his or her support needs.* The milestone payment is in stone, a locked in amount that pays once a milestone is achieved no matter the person's needs or disability. This point is referencing the ongoing support and follow-along payment which means a provider may receive a greater reimbursement if the person has been on the job for a greater amount of time or if the person has a more significant level of disability or challenge, or if the person's number of hours are greater.*

    This means that providers may receive greater than average reimbursement in three different ways: by keeping the person working, by working with persons with more significant disabilities, and by ensuring persons are working more hours.* Because the providers are incented by any one of these three factors, providers are incented to just place the highest

functioning folks who are working more hours, are more likely to continue working, and need the least amount of support and follow along services. Placing persons with significant disabilities is a risk to the provider from the very get-go since VR funding is extremely limited and the provider won't get paid if the milestone outcome is not fully achieved. It's a financial risk to the provider if the person is working but a few hours on the ongoing support and follow-along side, unless he or she is being concurrently placed in a day center when not working. Placement in a day center while the person works in supported employment a few hours a week, gives the provider the ability to draw down an ongoing support and following along amount even if the person works 9 or fewer hours a week and, **additionally**, an hourly or day rate for the person's daily attendance at the day center facility when not working.*

14. In the milestone/tiered payment system, the payments received by the providers of services are rebalanced based on staffing ratios. This means that the amount of payment the provider receives is lessened if the service is delivered to a group of people with disabilities.*

    This is the same with hourly fee for services rendered reimbursement. It is critical for the success of employment to eliminate any financial incentive to congregate, segregate, or group citizens in any manner, in a facility or in non-facility services. For example in hourly or fee for services funding rendered payment system where for example reimbursement for 1:1 individual service could be $48 per hour, putting 2 people together would cut the rate in half to $24 per hour, 4 people means $12 per hour, 10 people equals $4.80 cents per hour, and a 20:1 workshop or day center ratio equals a provider payment of but $2.40 per hour per person. This allows the state to create a true neutral funding mechanism that simply says, group if you must but we're not going to pay you more than what we have determine to be your acceptable costs for doing so, and we are not going to financially incentivize grouping in a day

center or workshop when compared to the rates we are paying for individual employment services in the community.

The tiered funding methodology addresses this in a vague manner by simply lessening the congregate funding instead of cutting it based on an exact staff to person ratio.* While the hourly ratio allows providers to be paid the fair amount to cover acceptable costs no matter the ratio, merely lessening the amount for day center services in a tiered system, likely incents congregation of participants.*

15. The payments for community based wrap-around supports, such as community participation and community access services are developed separate from the manner reimbursement is determined for employment services with milestone payment tiered funding.

The 3rd, 8th, and 9th Federal Courts have ruled that all payments to providers of Medicaid Services must be based on the actual costs of services and that States may determine what costs are allowable and to what degree.* Proponents of tiered-funding want to incentivize, pay providers significantly more, even if it means paying them more than their expenses to provide the service, for employment services. Setting up separate funding mechanisms, payment structure, for services that are not employment-related, leads to a funding inconsistency that is likely to result in the continued incentivizing of congregate day services, both facility and non-facility.

An hourly payment methodology across all supports and services, including non-facility and facility based services, not just employment, would allow Kansas to set a logical consistent and transparent cost based reimbursement methodology that each provider can count on to pay his or her costs for any worthwhile service that is rendered.

How to Increase Provider Capacity

There are two ways to increase provider capacity: 1) by increasing the current providers capacity to deliver increased services in a higher quality manner; and 2) by increasing the number of additional high quality providers; both methods are needed in Kansas.

Increasing the current providers capacity to deliver increased services in a higher quality manner

1. Kansas Vocational Rehabilitation and State Medicaid should provide an hourly rate of pay that allows providers of services to pay the same as the Kansas average annual teacher salary for nine months of employment for Job Developers/Employment Specialists/and Job Coaches who will make that same salary over twelve months—effectively 75% of a Kansas teacher's salary.

   The average beginning teacher salary in Kansas is $33,387 and the average salary for all teachers in Kansas is $47,464. This means that providers would be paid between $44.51 and $63.28 per hour, depending on the salary and benefits paid to Job Developers/Employment Specialist/Job Coaches. As a point of reference, A beginning employment specialist who made $19,000 thirty years ago in 1985 when Supported Employment was beginning would make a beginning salary of $42,141 adjusted for inflation today in Kansas.

2. Eliminate separate job developer, employment specialist, and job coach positions and create a single position that would provide all Discovery, job development, on site training, and support and follow along services. The title Employment Training Specialist should be considered.

3. Ensure that all payment for Supported and Customized Employment is based on full time employees (100% FTE) providing the supports and services, discouraging all part-time Employment Training Specialists.

4. Eliminate milestone or outcome payments or increase the total amount paid to ensure providers have the necessary resources to provide job development and job site training. If a milestone payment rate is mandatory, the amount of the total payments should be increased from $3500-4500 to $11,700 in Kansas, the equivalent of an hourly fee for services rendered payment.**

5. Ensure staff development/inservice training costs are built into the rate at an amount between 2% and 3% of the person's annual salary. This amount is to be used for conference attendance, inservice training by outside or national experts.

6. Eliminate disincentives to community employment by eliminating unintended fiscal incentives to group people. For example, while a rate of $52 per hour for supported employment, customized employment, or individual time-limited community connection or community access services may seem high, a provider of day services that is allowed to group or oversee up to 20 persons at a rate of $3.00 per hour is the equivalent of $60 per hour. It is not uncommon for ratios in workshop or day center settings to generate several hundred dollars per hour, far more than is possible with individual fee for service rendered individual hourly reimbursement. In fact, facility billing is continuous, never-ending, and mostly everyday billing, unlike supported employment or customized employment where the taxpayer does not fund every minute just because the person is working. Note: This is not the case with tiered funding that is mostly based on the provider being paid more if the

person is working more hours even if no Medicaid services or limited Medicaid services of just a few hours a month have been provided.*

Increasing the number of additional high quality providers

1. Allow both traditional Medicaid service providers who have been designated by state Medicaid as a provider of Medicaid services and who hold a unique provider specific Medicaid vendor number, *and* ***non-traditional Medicaid service providers who provider services to 1 to 3 persons or are an employer who is a provider of a discrete on-the-job skill.*** Both of these non-traditional providers could be included in the person's person centered plan. Neither of these non-traditional providers would have an assigned Medicaid vendor number, but would provide services under the Financial Management Services vendor number.
2. Encourage new providers of services from current experienced employees of traditional providers by allowing non-accredited but state certified non-traditional providers who are limited to providing services to 1 to 3 persons. These non-traditional providers would use the Financial Management Services (fiscal intermediary) Medicaid contractor to bill for services rendered.
3. Create the following independent single service providers: independent conflict free case management, community guide services (support brokerage), fiscal management services (fiscal intermediary), transportation services, discrete skills providers (employers), etc., and consider the potential of allowing participant-direction of any service to be provided as a sole service provider, such as: customized employment, supported employment, community connection or community access services, etc.

How to ensure a high quality workforce with low staff turnover

1. Ensure that at least 70% of the rate of payment is the salary of the professional directly providing the services, the Employment Specialist.
2. Encourage a performance portfolio system (tied closely to the employee's job description) for the employee's first year of service, that rewards a permanent pay increase after completion of all required portfolio tasks, outcomes, duties, activities.
3. Use at least 2-3% of the hourly rate for funding outside staff development/inservice training, national consultants/speakers/trainers, conference attendance.
4. Pay Community Employment Specialists significantly above other entry level employees, equivalent to many of the organizations mid-level administrative personnel.

To create a seamless transition from school to integrated community employment:

1. Encourage and fund through Medicaid, paid jobs in the evenings, weekends, summers for all Medicaid eligible recipients (using mil levy, local, community tax. donation, or self-pay funding for non-Medicaid eligible students) ages 14 and 15. All employment would be paid at commensurate wage, be individual jobs without grouping of students, customized to the student's interests.

2. Require the Area Vocational Rehabilitation Counselor's attendance at least 9 times annually during the school year to inform and educate how the WIOA requirement that 15% of revenue be directed towards students will be spent in an individual by individual, individual plan and budget manner to support employment during the student's education from ages 16-21.

3. Eliminate all non-paid preparatory, non-paid work readiness, non-paid work experience, or any other non-paid work activity for students with disabilities.

4. Transform all 18-21 age school funded programs to non-facility, non-campus, real community, individual, no-groupings, paid employment at commensurate wage for jobs and community access services with membership in clubs, groups, association, churches, and businesses so that paid human service personnel, including the school paraprofessional is rarely if ever needed to be present.

5. Beginning at age 10, reduce reliance on paraprofessionals for all students with disabilities to the extent that by age 14 there is 90% less time spent in the presence of a paraprofessional or any paid or voluntary personnel other than a licensed Special Education Teacher.

6. Eliminate all non-paid, voluntary, exploratory experiences, to be replaced with commensurate pay for working in a real job in the community alongside other citizens who do not have significant disabilities.

7. Ensure all employment placements during the student's education years are not located in concentric circles around the school facility but are located near the student's home, neighborhood, and community.

To transition adults from facility-based services
to integrated employment in a steady pragmatic manner

1. Facilities should be closed in a manner that families, persons with disabilities themselves, and provider agency boards of directors feel that closing such places makes sense, as they are no longer needed.

2. The purpose should never be to close a sheltered workshop or a day activity center, but to build supports and services in the community to the extent that such places are rarely if ever needed.
3. Facility-based services should not be replaced with other services that congregate, segregate, or isolate persons with disabilities in any manner. This means that community participation or community access services should never be delivered to a small group in the community, not even to a group of 2 or 3. Grouping people because of their perceived deficiencies or challenges, rather than strengths and interests, is not made better by making the groups small instead of large.*****

4. Always transition one person at a time, which at first will increase the staff to participant ratio within the facility as first one then another staff member will be transitioned to connecting citizens—one person at a time--in clubs, groups, associations, churches, businesses, and employment within the community. After several months, the staffing to participant ratios will return to their previous staffing to participant ratios and then begin reducing further, allowing more individual attention within the facility.

5. Bring in persons who can teach and train personnel how to connect citizens with disabilities to clubs, groups, associations, churches, businesses and employment in a manner that a paid human service worker is rarely needed.

6. Increase pay, education required, and ongoing inservice training of Employment and Community Connection Specialists to ensure the staff turnover rate is less than 5% annually.

7. Continually downsize and then close a disability facility or program when it becomes no longer economically viable and it is harming other citizens from receiving services and supports.

To increase access to paid-work experiences, training, and internships such as Project Search

1. Project Search has become a very successful way to introduce students who have a disability to employment in a manner that builds the students' work skills, credentials, employment routines, and lifetime employment expectations. Employment in hospitals has significantly enhanced the image of persons with disabilities as citizens capable of working successfully alongside other citizens who do not have disabilities.

   Although not everyone with a disability has an interest in working in a hospital to the extent that it is likely he or she will make a living wage, Project Search participants have a proven work record in a complex environment, and should be considered by Kansas Vocational Rehabilitation Services as persons with significant disabilities who are likely to succeed in *any* future employment endeavor that matches the participant's strong interests.

2. Every Project Search participant should be concurrently a Kansas Vocational Rehabilitation participant. It is appropriate and likely that the source of funding for a Project Search student who has not been hired should come from a source other than Vocational Rehabilitation or the long terms support and services agency (DD, BH, etc.), such as the local education agency, other state agencies, and adult service providers knowing an investment in Project Search is likely to have a significant impact on the employment of citizens in their service area or region.

3. Paid work for students naturally occurs in the early morning hours before school, in the evenings after school, on weekends and holidays. Due to the historic likelihood of citizens with significant disabilities being employed at the lowest legally possible wage, working an average of 9 hours per week,

attending facilities where they work making less than one dollar per hour, placement in day centers without work, and constant community exploratory day services without employment, non-paid work experiences, where the employer receives some benefit, even nominal, should be avoided. All internships should be paid. Employment training should happen whenever possible in the context of a real job where the person is paid commensurate wages.

4. Discovery is tool to ensure students are matched to a job in a manner that significantly increases the likelihood of long-term employment success. Unlike competitive employment seeking that relies on applying for employment in competition with the general public for a posted job opening, formal resume development, and candidate interviewing, Discovery ensures an employment setting and circumstances that successfully matches individual interests with formal support, from both the employer and the provider of Customized and Supported Employment Services.

State Policy Implications

1. Formal funding agreements between Education, Medicaid, Vocational Rehabilitation, Behavioral Health, Children's Welfare Services, should be common with congruent employment funding and agreement regarding the methodology and payment rates to avoid interference with the habilitative and rehabilitative employment process through financial incentives or disincentives.
2. All persons with disabilities should have the ability to participant-direct any funding available for employment related supports and services, to choose both traditional and non-traditional providers of services, supported and customized employment, with assurance from the state that persons who provide a service must have the skills, abilities, and qualifications to deliver

the services as need in accord with the individual written habilitation and rehabilitation plan.

Analysis Follows Announcement Printed in Full below:

CMS Announces Performance-Based Payment Options for Employment Services Source: NASDDDS Federal News Brief September 4, 2015 At the HCBS Conference, the Centers for Medicare and Medicaid Services (CMS) announced new performance-based options for funding employment supports through a §1915(c) waiver. In essence, the option allows states to pay for employment outcomes based on a databased average amount of time expected to take to complete the service (based on actual data) and the cost per hour of service determined by the state. CMS would accept a payment structure that includes outcome payments for Discovery or Supported Employment Assessment Service and Report, or Job Development, Placement, Customized Employment Position, as a single unit of service as long as the service is time-limited, has a defined tangible outcome (such as a report or career plan in the first instance, or an actual job in the second). The state must articulate a rate for the service, then use data to develop an estimate of the average amount of service time needed to achieve the outcome. The outcome payment would then be based on the rate times the estimated number of hours. Under this structure, states can also make milestone payments in addition to fee-for-service to reimburse providers when certain employment outcomes are achieved. Payment must be based on fair estimate of effort (based on data) a provider must put in to produce these "above average" outcomes. CMS would also approve a plan to pay per hour worked by the supported employee as long as such payment is based on average percentage of job coaching time necessary to enable a person to retain employment (supported by data at outset and verified at intervals on an on-going basis). CMS also said they would accept tiered outcome payments based on an assessment of an individual's level of disability. The state must explain in their waiver application or amendment the number of tiers and how the state will

determine the appropriate tier for each waiver participant. If a state doesn't use tiers and instead has one reimbursement rate for everyone, CMS will ask if the state can demonstrate that people at all levels of acuity are getting access to the service and using the service to the same degree. These payment options, CMS, said, "require fiscal integrity structures that ensure a regular look behind at actual hours spent working with individuals to ensure that the estimates used to set payments remain accurate." CMS would not accept payment for a unit "where there is no expectation that any amount of service will be delivered by the job coach." CMS also requires that any structure that involves paying per hour worked by the supported employee must expect fading of paid supports over time, since CMS expects that the longer an individual is in a job, the fewer supports they will need to maintain employment. In addition, payment adjustment is required when a job coach works with multiple individuals in a job site. In the presentation at the HCBS conference, CMS officials stated that this was to avoid incentivizing congregate work arrangements. CMS will also require that there is no organizational or financial relationship between the job coach and the person centered care planner/case manager.

What this means:

- The hourly cost per hour of service must be determined by the state as the basis for allowing states to pay for performance-based employment outcomes payments. No longer can the performance-based outcome payment be set arbitrarily such as $500, $1000, $2500, $750, etc.
- If a state uses performance-based outcome payment, the payment must be a databased average amount of time in hours expected to complete the service.
- The performance-based outcome payment must be based on the provider rate times the estimated number of hours of service that will be provided.
- States can also authorize the payment of fee for service hourly reimbursement in addition to milestone payments.

- The performance-based outcome payment must be based on an estimate of the number of hours (data) it is going to take to produce the promised outcome.
- The data used to determine the performance based outcome payment is based on the time, the amount of hours worked, that a provider would need to deliver in order to justify the payment.
- CMS would approve a state's plan to pay for hours the supported employee works but the payment of hours x the rate must be based on the average percentage of job coaching necessary, supported by an estimate of the number of hours of job coaching necessary at the outset and verified at intervals ongoing, **adjusted with the CMS expectation that supports will be faded overtime, since CMS expects the longer a person is in a job, the fewer paid supports the person will need over time.**
- CMS also said it would accept tiered outcome payments based on the person's level of disability. It is assumed this would mean level of need relative to other eligible persons with a similar disability.
- If a state decides to use tiers it must explain to CMS how a particular tier was appropriate for an individual, instead of one of the other tiers.
- If a state doesn't use tiers and has an hourly individual fee for services rendered payment mechanism the state must demonstrate how an hourly individual fee for services rendered payments will ensure all persons are getting access to services to the same degree, likely more services and supports for persons with more significant disabilities and less services and supports for persons with fewer significant disabilities.
- CMS is requiring states to have "fiscal integrity structures" that ensure regular look behind, **ex-post facto data collection, of actual hours spent working with individuals to ensure that the estimates used to set any tiered payments remain accurate.**
- CMS will not accept payment for a unit of service "where there is no expectation than any amount of service will be delivered by the job coach."

This however is not at variance from the long-standing CMS policy that services must be person specific, can be accomplished on behalf of the person, such as community job development, without the person present, and also when they are authorized to advocate on behalf of the person with family members, the employer, coworkers, residential support staff, etc., and other community members without the person present. Person-specific job coaching duties must not be and cannot be always face-to-face on the job training, OJT. The failure of just OJT to secure and ensure employment of citizens with significant challenges to employment was an important reason for the creation of Supported Employment in the Rehabilitation Act revisions of 1986. Supported employment was created in recognition of the many variables to employment success and job coaching and is much more than face-to-face training or interventions.

Here is the much earlier guidance from HHS on this issue:

Payment and Contracting Policies

An important aspect of system design for ensuring access to home and community services while promoting cost-effectiveness involves two intertwined topics: payment and contracting for services. Payment policies should encourage the economical and efficient delivery of services, while also enabling a sufficient number of service providers to participate to ensure that the needs of clients are met. Further, contracting policies should foster efficient service delivery and may aid in expanding services availability.

Payments

It is frequently, but mistakenly, believed that Federal policy prescribes precise methods states must follow in purchasing Medicaid services. In fact, Federal policy requirements with respect to Medicaid payments are quite basic:

States may generally not pay a provider any more than the provider charges other third parties for the same service.

Except in certain circumstances (discussed below), a state's payment must be tied to actual delivery of a covered service to a particular beneficiary.

State payment levels must be high enough to attract sufficient providers to meet the needs of beneficiaries.

States are expected to be "prudent buyers," seeking out providers who will furnish services most economically while avoiding providers that have excessive costs.

Within these broad parameters, Federal policy gives states considerable latitude in the methods they use to make payments for home and community services. Thus, states may (and do) use any of a wide range of methods to determine the amount they will pay for home and community services. States may also use different methods for different services. Methods in current use include:[15]

Fee-for-Service Price Schedules. The state establishes a uniform payment rate that applies to all providers of a service (e.g., compensating nursing services at the rate of $35 an hour regardless of the organization furnishing the services). Personal assistance attendant services are frequently reimbursed on this basis.

Cost-Based Payments. The state bases payment rates on the allowable costs incurred by the specific provider, usually accompanied by upper limits on costs to encourage cost-effective service provision.

Negotiated Rates. The state bases payment rates on the specific provider's actual or expected service costs.

Difficulty-of-Care Payments/Rates. The state pays providers amounts that vary based on expected differences in the intensity of services and supports specific individuals require. Such methods seek to improve access to services for individuals with particularly complex needs and conditions.

Market-Based Payments. The state purchases goods and services from generic sources (as in the case of engaging a contractor to install a wheelchair ramp or to connect an individual to an emergency response system offered by the local telephone company).

Medicaid payments for services are unit-, encounter-, or item-based. Units are usually expressed in terms of time (e.g., hours, days, months). Encounters may include contacts--an intervention (e.g., a mental health counseling session) that may differ in duration depending on the needs of the consumer, or various other means of establishing a documentable tie between the payment and an activity on behalf of the individual. Payment rates are tied directly to the billing unit or encounter established by the state. Medicaid accountability requirements mandate that claims for service payment be based on defined activities performed on behalf of eligible beneficiaries. Item-based payments are employed to secure home and vehicle modifications (e.g., installing a van-lift) as well as equipment and supplies (e.g., communication devices). Item-based payments are used for one-time purchases or buying supplies from approved sources. (For managed care purchasing alternatives

see discussion later in this chapter.)

State payment methods for home and community services are not usually reviewed in depth by HCFA during its review of state Medicaid plan amendments or an HCBS waiver application renewal. Such methods may be reviewed in the course of other Agency activities to ensure they comply with basic Federal requirements.

Correcting common misperceptions

There is no Federal requirement that payment may only be made for services furnished "face to face." It is not true that providers may only be paid for the time during which they are providing direct, "hands on" services in the presence of an individual. It can obviously take time for a worker to travel to the individual's home. In the case of certain services, advance preparation may be required. And case managers frequently conduct activities on behalf of individuals (e.g., arranging for an assessment or locating home and community services) that do not require the consumer to be present. When payment policies fail to take such additional time and effort required into account, providers understandably can be reluctant to offer services.

Medicaid payments may be made for all these types of activities, since they are recognized as integral to delivering the home and community service. States may compensate providers for the time they spend in addition to the face-to-face part of the activity in either of two ways: (a) directly, as long as the activity falls within the scope of the service itself (as defined by the state in its Medicaid State Plan or waiver program), and benefits a specific individual, or (b) indirectly, by adjusting reimbursement rates to take into account the additional activities necessary to furnish the service.

U.S. Department of Health and Human Services

Understanding Medicaid Home and Community Services: A Primer

Gary Smith, Janet O'Keeffe, Letty Carpenter, Pamela Doty, Gavin Kennedy, Brian Burwell, Robert Mollica and Loretta Williams

George Washington University, Center for Health Policy Research October 2000

This report was prepared under contract #HHS-100-97-0015 between the U.S. Department of Health and Human Services (HHS), Office of Disability, Aging and Long-Term Care Policy (DALTCP) and George Washington University's Center for Health

Policy Research. For additional information about the study, you may visit the DALTCP home page at http://aspe.hhs.gov/daltcp/home.htm or contact the ASPE Project Officer, Gavin Kennedy, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. His e-mail address is: gkennedy@osaspe.dhhs.gov.

To Continue:

- CMS expects payments to be adjusted to account for a job coach who is working with multiple individuals at a job site to avoid financially incentivizing congregate work arrangements.

- CMS is requiring there to be no organizational or financial relationship between the job coach and the person's case manager responsible for writing and monitoring the individual's plan of care.

Customized Employment Changes

- States are welcome to submit a payment structure that allows outcome payments for:
  a) Discovery;
  b) A Supported Employment Assessment and Service and Report;
  c) Job Development;
  d) Customized Employment Position as a single unit of service, provided that it is a time-limited service with a defined outcome that can be identified for payment, for example job obtained.
- The payment for any of the above listed Customized Employment or closely related services must be based on the average amount of time (based on actual data) that it is expected to take to complete the service and the cost per hour of service that is determined by the state, eg. 50 hours of service x $40 per hour = $2000 outcome payment for example.

Summary:

The timing of the CMS announced changes are fortunate for Kansas. This means changes may be made considering the very latest CMS guidance. **With the big exception of changes to Customized Employment and Discovery becoming new units of services**, the new CMS guidance will do little to encourage providers to provide supported employment and customized employment services.

Many of the CMS changes were designed to deal with the problem of past and current government agent recommendations (self inflicted system wounds) that were at variance with CMS and the Medicaid Act. These recommendations

encouraging states to set up tiered funding systems and to fund them with rates that had little regard for the amount of services provided and no consideration for the provider's actual cost of providing those services.

CMS has mandated that ALL funding systems must be based on the state setting an hourly reimbursement methodology—even for performance-based or milestone payment methods—will bring welcome accountability for the use of the taxpayer's dollars. These changes will make states who desire to set up a milestone payment and tiered funding system of payment more accountable, with routine auditing of the basis for reimbursement, impacting milestone and tiered funding systems with the potential provider to government paybacks whenever the amount of services and costs are less than the amount of the rate paid.

Unfortunately these changes continue the practice of trying to make milestone/performance based and tiered funding systems, the funding systems that have discouraged integrated community employment for many years, better. Hopefully subsequent guidance with Self-directed Employment Services from CMS will finally free Kansas and other State systems to be more creative with the assurance that providers of services will always be fully paid for their costs of providing services.

The providers in Kansas are waiting for an employment financing system that encourages employment of citizens with disabilities in the community, a financing system that made Kansas one of the top states in the community employment of citizens with developmental disabilities in the United States—a system a lot like the one that Kansas providers of services once had, throughout the 1990s.