New Community Opportunities Training

Medicaid 101

Presented by Suzanne Crisp

Transcript of the presentation on January 30, 2013:

>> HOST: Good afternoon, ladies and gentlemen. Welcome to the   
Medicaid 101 conference call. All lines are placed in listen-only   
mode. The floor will open for questions and answers periodically   
throughout the presentation. I turn it over to your host, Mr. Tim   
Fuchs.  
>> TIM: Good afternoon. I am with the national council on   
independent living in Washington D.C.. This is our newest webinar   
program: Medicaid 101 presented by the new opportunity center,   
national training assistance prog ILRU in Houston, Texas.  
It was organized and facilitated by thousands of us here at   
Iindependent council for independent living.  
We will break several times during the presentation to take   
questions today. The webinar participants can ask questions at any   
time, and we will see them.  
You won't see them displayed until the Q&A section, but we are   
getting them. You can type questions into the public chat in the   
text box under emoticons on the web that are platform.  
A change for today's program, we are not running audio through   
the webinar. All of the audio is over the teleconference. But   
don't forget the webinar platform does take questions, you are   
welcome to enter your questions that way.  
Same with the CART captioning, you can type questions in that   
"chat" feature during the presentation and I can voice the question   
for you at a Q&A break.  
For those on the phone, you can press "7" to indicate you have a   
question during a Q&A break, and you can ask your question live in   
the order it was received.  
If you are on the web that are, you will see that the Power Point   
will display automatically for you, which is a nice feature. If you   
are just on the phone today, that is fine.  
But do make sure you open the Power Point. It was e-mailed to   
you in the confirmation. You really will want to follow today's   
presentation. It will help a lot. Also following our call, there   
is an evaluation form online. We will.  
If you are on the phone, we will ask you to log into a computer   
and fill it out. It is very short, quick and easy to complete. It   
is very important to us. I do hope you will fill that out.  
I will mention this at the end of the call as well, but on   
February 13th we will have another presentation, again with Suzanne   
Crisp and Bruce Darling on affecting change within Medicaid and   
community service program.  
It will be focused on CMS, but more of an intermediate-level   
presentation. It isn't part of a series, but there is a lot of   
relevance.  
I hope you will all consider signing up for that. It will be   
announced in the morning, so you haven't missed anything.  
Check your e-mail in the morning, check our website too. It will   
be posted, and you can sign up for that February 13th event. I will   
again remind you at the end of the call.  
Thanks for bearing with me. Without further ado I give you   
Suzanne Crisp, an expert on Medicaid.  
I have worked with her a number of time. She does a really great   
job. Officially she is the director of program design and   
implementation for the national resource center for participant   
directed services at Boston College.  
Suzanne has frequently work with and trained advocates and is a   
big advocate of program herself.  
I know you will enjoy working with her. If this is your first   
time in one of her trainings, and for those of you who have heard   
her before, I think you know this will be a good one.  
I will turn it over to Suzanne to begin.  
>> SUZANNE CRISP: Thanks so much, Tim. It is a pleasure to be   
here, conducting these webinars, a very fun aspect of working with   
ILRU, which should make you suspect about the level of my sanity if   
I on joy talking ad nauseam about Medicaid!  
Hopefully this will be inspirational for us all. Today we will   
present the basic structure of Medicaid. Also I aided a few   
Medicare slides because it has increasingly become a national trend   
to look at both Medicare and Medicaid to see how we can improve the   
case coordination of our dual-eligibles, about four slides on that.  
We will also talk about Medicaid services, a bit dry, but we will   
try to make it interesting. We will discuss selt or consumer   
direction and toward the end, highlighting strategies for appealing   
decisions made by Medicaid.  
In the next slide I want to talk about how Medicaid came to be.   
I don't know how old you all are out there, but I guess I was in   
high school -- no, it was college I was attending at 1965.  
I had no idea what was going on would impact American health   
care. But Lindon Johnson created "The great society" with   
legislation enacted to create Medicare and Medicaid and social   
security.  
Think about what would happen if the great society had not been   
implemented? We wouldn't have any of those very, very important   
programs. That is a very significant year.  
In the very early years, Medicaid was simply minimum health   
insurance for people who were passed 65, for dependent children or   
for persons with disabilities.  
It was state-funded and considered a welfare program. It had   
very low-income and resource thresholds. It really was just a basic   
healthcare plan.  
We know that all has changed now, and we will look at a few   
slides to show the growth of Medicare in the past several years.   
Medicaid is a jointly-administered program by both the state and   
CMS.  
CMS implements regulations and policy interpretations that   
provide the framework for the Medicaid program, and then states   
takes that framework and create their own unique designs.  
On the other hand, Medicare is a social insurance for everyone   
who has paid during their working years. If you look at your   
paystub it says Medicare taxes, and FICA is the social security   
portion of your taxes.  
Medicaid is only for individuals with low income and limited   
resources. Again we will talk about what "low income" means and   
what those limited resources are.  
Our next slide, I just want to con say it will be somewhat of a   
challenge because both Medicare and Medicaid are very, very complex.   
I don't know everybody who knows everything about Medicaid, or even   
one person who knows everything about Medicare, much less people   
that know both those huge federal programs.  
With Medicaid, it gives us the opportunity to create home and   
community-based services.  
  
There will be a slide a little later that talks about how the   
community services were first developed and how important they are   
to us in our day-to-day lives today.  
Changes to Medicare and Medicaid require congressional action; in   
other words, Congress has to say we want to make a change in the   
code of federal regulations.  
We saw many changes come about with the Affordable Care Ability,   
and we will get into details about that later too.  
In general, state legislatures decide how much the state will   
spend for Medicaid. It sets income limitations and resource guides,   
whereas for Medicare, it is a federal program that looks the same   
across the nation.  
States also decide how much to pay Medicaid providers through a   
rate-setting process, whereas Medicare rates are set by the federal   
government.  
I don't think this is any surprise to any of us, and it isn't   
meant to be pejorative. But those with knowledge about Medicare and   
Medicaid are typically not change agents or advocates. They are   
typically very detail-oriented people that see things in black and   
white, rather than in shades of gray.  
That will be a challenge as we try to identify changes and try to   
make those changes within the Medicaid system. Not only is it   
tough, but people are not so inclined to make changes readily.  
The next couple of slides will be about Medicare. Medicare, we   
know it is a health insurance plan that we pay into as we work. The   
program is quite expansive.  
Right now the enrolees number about $44 million and 7 of that is   
adults with disabilities. Medicare comprises 13% of the federal   
budget.  
If you watch the news, you know this is a topic for continuous   
discussion about sustainability of Medicare and the value of   
Medicare.  
Medicare funds are acute care services funds. Acute care   
services things are things like hospitalizations and therapy   
sessions and trips to the ER.  
Medicare is divided into four parts. The reason I am going   
through this, you may have people that come in for assistance,   
community assistance to talk about the various parts of their   
Medicare and how that fits in with Medicaid.  
So it is somewhat important that we understand what the four   
facets of Medicare.  
The first is Part A. It is for hospital nursing if a still sees,   
home and health services, across the nation, doesn't vary by state.  
Part B is doctor visits and outpatient care and prevention   
services.  
Part C is fairly new, an opportunity for people to engage with a   
private company to combine both "A" and B, an offer them services   
that are covered under "A" and B.  
And often times, adding additional coverage. If a person says   
they are Particle C and they have Medicare Advantage, you know they   
have a little different plan than just regular Part A and B.  
Another handy thing about Part C, private companies can offer   
lower co-paying and deductibles.  
You might find your constituents asking questions about what is   
the best Medicare advantage company, which requires quite a lot of   
research.  
Part D is prescription coverage, which is also new. It creates   
private healthcares that provide prescription coverage, or we have   
been seeing part C picking up prescription drug services too.  
I guess the most comprehensive plan would be Medicare Advantage   
plan that managed part A and B and D. That would be the least   
confusing to individuals in our communities.  
Also there are limits with Medicare on long-term services and   
supports. Medicare reimburses nursing facilities 180 days only, and   
that is if you are dismissed from a hospital and you need   
rehabilitation. They pay 180 days.  
That is the extent of the long-term support offered under   
Medicare. It is an entitlement program, so if you are eligible, you   
do receive that you need.  
On the next slide we talk about Medicare eligibility. You need   
to be 65 and pay contributions to Medicare taxes for at least ten   
years.  
Individuals with disabilities must meet specific disability   
listings, and? Your state you are probably familiar with the state   
unit of social security disability determination.  
This is the state unit that is funded by the federal government,   
but its operations are state people. Each state has an office of   
disability determination. It is here that people make application   
for disability, if they are less than 65 and they need social   
security and Medicare, then they must go through this state unit.  
  
To be eligible for social security payments, individuals with   
disabilities have to wait two years. I haven't ever researched the   
reason for this, but I do think it is a form of discrimination  
So what the state is saying, you are totally disabled but you   
can't draw Medicare for two years.  
To me, that seems peculiar because if a person is disabled, they   
definitely need healthcare coverage, so we need to do some homework   
on that to see how what we would need to do to get it changed.  
Medicare covers basic health services, as we said, and it also   
involves a pretty substantial cost-sharing, premiums and deductibles   
and copays have to be met.  
The last Medicare slide shows things not covered by Medicare.   
They typically don't cover long-term services and supports, except   
for that 180 days in a nursing facility, they don't cover ventral or   
vision or hearing aids.  
So now let's look at immediate Medicaid and see how that works.   
I do occasionally get mixed up with the two, Medicare and Medicaid.   
The names are so similar, it is easy to get them mixed up.  
This slides talks about the Medicaid program, the largest public   
health insurance program in the U.S. covering over 60 million low   
income people. In other words, one out of five people are eligible   
and receive Medicaid.  
It is the largest payer of all loan-term services and supports.   
And here, long-term services and supports are those supports treat   
chronic services in usually the home or a nursing facility.  
  
Versus acute care, episodic in nature. I go to the doctor or the   
hospital, there is a start and stop. But with long-term care, it is   
a continuous maintenance program.  
The Affordable Care Ability gave substantial changes to Medicaid.   
As you probably know, they call it Obamacare now, but the act was   
passed in March of 2010.  
One of the significant things is that from 2014 to went 16, the   
federal government will (2016) the federal government will finance   
a hundred percent of the costs for individuals newly eligible for   
Medicaid due to the expansion.  
Obama Care wanted this expansion because they felt there were so   
many people out there who had low incomes, maybe not to the low   
income threshold of meeting Medicaid.  
But still there were people just above the threshold and who were   
uninsured. Hopefully states will see the value of this and will   
implement programs that will encompass this new eligibility   
enrollment.  
I know a lot of states are reviewing whether or not to do this.   
A lot of states are fully on board with it and they are right now   
developing expansion strategies. It will be interesting to see how   
that all works out, but it is limited to two years.  
On the next slide we see Medicaid provides us with the   
opportunity to provide long-term services and supports. Here we   
have a little terminology change.  
It used to be long-term care, but as the disability community has   
taught us for years, the word "care" is somewhat maternalistic with   
more of a negative instead of an empowering context.  
So after years and years, the federal government listened and are   
now calling it: Long term services and supports. So if you see the   
term "LTSS" that stands for long-term services and supports, and it   
is commonly used.  
Initially Medicaid in the 1965 and the later '70s and early '80s   
provided assistance with long-term care only in the form of add mics   
and into a nursing home facility or an ICMFR, institute for mental   
retardation.  
Home nursing has a skilled care component to it, as well as a   
nurses aide component, more personal-type care. The social security   
act was amended in 1984 to allow a choice between   
institutionalization and waiver services.  
I will tell you a little bit more about how that came to pass and   
the significance of that, and give you a little overview of the   
advancements that were presented in the '80s.  
Until 1988, it was 90% of all Medicaid funding being dedicated to   
nursing facilities or institutional care facilities for the mentally   
retarded.  
"mental retardation" is a term that also queries a pejorative   
connotation, and the government has been slow to formally make the   
change. But they do recognize intellectual with disability is the   
new term.  
Many state program are being renamed, taking out "mentally   
retarded" in all policies and procedures and ledge cakes, replacing   
it with "intellectual disabilities" which is a very good thing.  
The next slide, each state operates their own Medicaid program by   
developing a state plan. . The state plan is a living document   
which can be amended, but with a of trouble which I will tell you   
about in a second.  
  
But it outlines the plan for what the state will do for their   
program. Then it is submitted to CMS, the federal agency that   
oversees Medicaid and Medicare.  
The state submits the state plan to CMS, and CMS approves it.   
Then if there are any changes the state wants to make, they have to   
formally amend their state plan. So if you hear talk about a state   
saying we would love to do that but we have to amend our state plan,   
know that is a pretty rigorous process involving ledge lation   
approval at the state level.  
And then at the federal level too, the scrutiny is quite close.   
So if CMS has approved it and you submit an answer mendment, it does   
open things up to scrutiny. Some states are pre-sive about quickly   
making changes in the state plan.  
Medicaid mandates some services, and allows other services to be   
optional. We will cover that in just a second.  
  
States choose their eligibility groups, the services that will be   
provided, the payments that will be made for reimbursement. It also   
controls provider qualification, who can come into the program and   
actually provide services and be reimbursed by Medicaid.  
In 2009 there were 31 million children on Medicaid and 6 million   
elders and 9.5 million persons with disabilities. For the purposes   
of this course, as well as many of the things that come from   
Medicaid, they don't differentiate between the persons with   
disabilities and persons with IDDD diagnoses, or persons with mental   
health or behavioral health diagnoses.  
So what you have is a great big lump of people that includes a   
wide range of disabilities.  
We can go deeper an look at persons with physical disabilities,   
and we will be giving you a resource on how to capture that data,   
how to retrieve that data from your state toward the end of the   
presentation.  
The next slide outlines an expenditure overview. We know 15% of   
individuals with disabilities expend 43% of the funds. Keep in mind   
that this 43% does include intellectual and developmental   
disabilities, and that group is usually the highest-reimbursed   
population group we see.  
Another thing I would like to draw your attention to, the   
maintenance of chronic illnesses versus acute care and hospital   
visits, two thidz goes to acute care and one-third is long-term care   
services and supports.  
Let's look at the role of the state agency. Each state has a   
dedicated Medicaid agency that is responsible for both developing   
and managing and operating the Medicaid program.  
They must ensure accountability between the state and the federal   
government; this office does that. It is somewhat limited in what   
the Medicaid agency can delegate.  
They have to keep certain functions. For example, they have to   
maintain developing quality assurance plans. They cannot delegate   
rate-setting or the development of provider qualifications.  
There is a department of human services, one large agency or   
office or department, and then under that department there are   
umbrella agencies operating Medicaid programs.  
There is a state medical program with full authority over the   
Medicaid program. Then often times the Medicaid program degates to   
either divisions on aging and adult services or developmentally   
disabled divisions.  
They allow those entities to actually manage the program. If you   
want to try to make a change and your division says no, Medicaid   
won't let us do that. What they mean, they are a state Medicaid   
agency who has total authority over the Medicaid office; that would   
be the office that would manage that change.  
The people at Medicaid, there are very few change agents there.   
I know that because I used to be one of those people, and the   
mentality is to keep a tight hold of the budget. Not to be unkind,   
but that is simply their job.  
The state also determines their own unique programs. The next   
slide is our "question" slide. I think we have a lot of questions.   
I haven't been reading them. Tim, if you can field them for me, it   
would be wonderful.  
>> TIM: I will, with the help of amen da. If you can give the   
instructions for people on the phone while we wait for the queue to   
populate, I will read the first webinar question.  
>> HOST: Floor is now open for questions. If you have a   
question, press number 7 on the phone keypad. Questions will be   
taken in the order received. If at any point your question has been   
answered, you may again press 7 to disability your request.  
If you are using a speaker phone, we ask that while you pose your   
question, you pick up the handset for favorable quality and sound.  
>> TIM: I will go ahead with this question from the web.   
Margaret Sevins, question about going back to the overview of   
Medicare.  
Which parts of Medicare have premiums? And how much are they?  
>> SUZANNE CRISP: Good question. Part A and B and C and D have   
premiums. Then if you do have a health plan under C, there are also   
premiums.  
I was looking last night on the website in preparation for this,   
and basically the deductibles are in the thousands of dollars. It   
can range from like 1,000 to 3,000 dollars, something like that,   
depending on what the service category is.  
Co-paying are generally what the cost of the service is.  
  
Premiums are anywhere from 100 to 400 dollars a month. Not only   
do you have to pay into Medicare when as you are working, but once   
you start drawing it, you still have to pay in to receive it, kind   
of like your own private healthcare company. You have to pay a   
premium to receive it.  
If you don't pay the premium, you won't receive Medicare. In the   
Medicaid program -- I know I will get this wrong.  
But it is the -- let's see. It is the qualified Medicare   
beneficiaries program where Medicaid does not -- it covers only the   
premiums for Medicare for a certain class of people.  
So it is kind of complicated, and I am not the Medicare expert.   
At the end of the session I will give you information about how to   
go on the Internet and get more detailed information, if I haven't   
done a good job.  
>> TIM: Next Eric has a frustrating situation. He says recently   
they have noticed a number of their clients who have been talked   
into a Part C plan, sometime feeling bullied.  
After signing up for the plan, they find out it messes up their   
medical coverage with their doctors and prescriptions, et cetera.  
They have run into this problem at large pharmacies like   
Wal-Mart. They feel like they are being targeted to Medicare   
recipients.  
Eric wonders if you know about real lakeses with regard to   
selling individuals these plans?  
>> SUZANNE CRISP: Yes, there are regulations. Which is why it   
is helpful to go to the Medicare website to see what it has to say   
about it.  
Remember that these private healthcare companies really want the   
business, kind of like a managed care entity they have created.   
Medicare Advantage allows a for-profit private healthcare agency to   
kind of manage the Particle A and Part B.  
So with that, as we know with managed care, there is sometime a   
limitation of free choice of providers. Some providers don't accept   
the plan, steerlg you outside of your normal freedom of choice   
situation.  
Without going into too much detail, there are regulations about   
the integrity and ethical considerations about talking people into   
Part C. But I do encourage us all to go to the Medicare website, as   
opposed to some of these healthcare websites. That way, you can get   
the real information.  
Keep in mind I don't get out too much anymore, but the aging and   
disability resource centers are supposed to be having a Part C and   
Part D counseling which is pretty intensive.  
I don't know if it is effective, but I know they have been   
charged with helping people make those decisions.  
>> TIM: Let's go back to the phone.  
>> HOST: There is a question, with two more on the line.  
>> This is Sheila. I have a consumer right now who needs to see   
an ear, nose and throats doctor. No one would take her. It was   
either children or over 65, and she didn't quite 65.  
>> SUZANNE CRISP: Is that it? Sheila, I think I got the   
message. Medicare providers, there are certain qualifications.   
Those who meet the qualifications can come forward and become a   
Medicare --  
>> Medicaid.  
>> Miami, 150 mile round trip, that is expensive. She needs   
surgery on her ear. She has had brain tumors before. The only way   
to get to the one doctor in Miami is to spend --  
>> SUZANNE CRISP: Medicare works the same as Medicaid.   
Providers can come forward and enroll. This is a lot of paperwork   
with both program, and not everybody is willing to go through that   
paperwork.  
A lot of people feel like the reimbursement rates for Medicare   
and Medicaid are so low, they simply do not want to enroll. And   
that is really outside the Medicare or Medicaid purview.  
It can do things to try to entice providers and physicians and   
hospitals to enroll, but if people aren't willing to enroll, there   
really isn't much the federal government can do about that.  
I believe the Affordable Care Act does have some incentives,   
particularly for physicians to not only keep enrolled but also to   
accept more Medicare and Medicaid patients.  
So I really don't have a good answer for you.  
>> Thank you.  
>> HOST: If you have a reminder, press 7 on your telephone   
keypad. There are no questions waiting at this time.  
>> TIM FUCHS: That was the end of our question period. Suzanne,   
I turn it back over to you to go to Slide 14.  
>> SUZANNE CRISP: I am going to go back to my handheld telephone   
for sound quality reasons.  
Let's talk about Medicaid requirements. As all things tied to   
the federal government, it is very confusing and pretty complex.   
The Social security act created Medicare and Medicaid and social   
security, part of Johnson's "Great Society" so any changes to that   
will require federal legislation; Congress must weigh in.  
If you ever have the need, and toward the end I will show you   
how. But if you want to look up the Social Security Act or the   
state Medicare manual or policies issued by CMS, there are a number   
of websites that can provide you access.  
I don't know if you are familiar with federal law, but it is   
pretty confusing to read, as well as not being very clear. So know   
that if you look at the code of federal regulations, that will give   
you the law; it is the interpretation of that law which sometimes   
gives us challenges.  
States may not place limits on services or deny coverage to   
particular illnesses or conditions under Medicaid. So we do know   
that some illnesses and diagnoses, the state must cover them in a   
way to ensure the chronic illness is met and sufficient services are   
provided.  
On the next slide we have more requirements. Services for   
Medicaid must be medically necessary. This means a person just   
can't receive personal care or home health services as an   
entitlement; there needs to be a medical need.  
Everything needs to tie back to medical necessity, and sometime   
we have trouble understanding that criteria because it is set so   
high that only the sickest of the sick can actually obtain those   
services because the medical necessity criteria is created too high.  
Often time we have to advocate for lowering that.  
Third-party liability rules require Medicaid be the payer of last   
resort. If you have private insurance or are a Veteran or if there   
is any insurance involved, Medicaid will be the payment of last   
resort, which also includes Medicare.  
Generally, Medicaid is statewide. We will talk about waivers   
that can be geographical limited in just a few minutes, but mostly   
services are state-wide, particularly state plan services.  
As one of the tenants of Medicaid and Medicare, people are given   
freedom of choice of providers. Medicaid and Medicare both identify   
provider qualifications.  
Those people come forward and say I want to apply as a service   
provider, I meet these qualifications. Then people can hold   
themselves out in the community as a Medicare/Medicaid provider of   
services, an then people can select their provider.  
Now in the case of West Palm Beach and Sheila, the selection was   
limited because of lack of providers. So we need to find ways to   
entice people, particularly firsts, to come forward and become   
Medicare and Medicaid providers.  
State reimbursement methodologies must include methods to assure   
provider payments are consistent with the economy, that they are   
efficient and that they include quality of care principles.  
While we say they must be "efficient" that is one of the reasons   
why many providers choose not to participate in the Medicaid program   
as we talked about just a minute ago, because the reimbursement rate   
might be lower than private insurance.  
And certainly the associated pipe paperwork is not pleasant for   
the providers to manage.  
  
Eligibility is categorically related; in other words, it is tied   
to a certain population. These populations are elders 65 years or   
older, visually impaired, or under 65 with a disability.  
We said that the state determines the level of disability, the   
admittance, so they are the gatekeepers for disability   
determinations. We know that in 33 states if you receive   
supplemental security income or SSI, you automatically receive   
Medicaid card.  
And in 11 states, a person would have to enroll independently in   
the Medicaid program. It is also means-tested. That means there   
are certain resource and income considerations which we will   
discussion in just a minute.  
Our next slide talks about financial eligibility. Financial   
eligibility is set by the state. States have the option to raise it   
to a hundred percent of the federal poverty level.  
In state plan as well as waiver services, we typically always see   
the federal poverty level as the gauge or the SSI level of payment   
as a gauge for admittance to eligibility.  
Some states have 75% of federal poverty level, while other states   
have a hundred percent. In later slides we will see that waivers   
also allow you to increase some eligibility by as much as 300% of   
SSI or 150% of poverty.  
It also allows employment options such as supported employment or   
a ticket to work. The medically-needy category -- let me back up.   
When people don't meet financial eligibility to be   
Medicaid-eligibility there is what we call spend-down or   
medically-needy.  
This is where a person has fairly limited income not sufficient   
to meet Medicaid, but they have some pretty enormous hospital   
expenses. They can come to the Medicaid office to apply for   
temporary Medicaid in the spend-down category.  
The amount they are over income, they can deduct medical expenses   
from their income, and then achieve temporary Medicaid eligibility   
not to exceed three months. That is always a good option for those   
with catastrophic health health events in their lives.  
  
you won't read all these, but it is a resource for later. I want   
to now draw your attention to nursing homes. Since the beginning in   
1965, nursing home have been a mandatory services service.  
So when we talk about the bias of nursing home, it is because   
nursing home were created in 1965 as a hand tore e service states   
had to provide.  
It has taken us all these years to create an optional program or   
home and community-based.  
We see personal care, daily grooming task like bathing and   
dressing and assistance with homemaking and shopping for errands,   
that was added in 1980. Prior to that time, services were not   
available except under the home health rule of Medicare, which is   
quite limited.  
Also notice that assistive devices and medical equipment and DME   
or durable medical equipment, those are optional services, as is   
case management.  
So states don't have to provide these services. There are about   
14 states that don't offer personal care in their state plan. They   
do offer some limited personal care-type services in waivers, but no   
state plan services.  
Now we're at a point where we can stop and ask questions.  
>>> TIM FUCHS: Amanda, please give the instructions again. Then   
I will take these two questions that came in over the web.  
>> HOST: If you have a question, press 7 on your telephone   
keypad.  
>> Tim M FUCHS: First see is from Ceale: Who covers service   
cost and copay and prescription cost with those with dual coverage,   
Medicare and Medicaid? Is it Medicaid or Medicare that picks up the   
costs? And also can you explain how someone becomes duly-eligible?  
  
  
>> SUZANNE CRISP: It is a good question. Medicaid picks up Part   
A and B. How they become eligible, when they sign up for Medicaid,   
they ask the question: Are you also eligible for Medicare? And   
then that goes into the system and they become earmarked as   
dual-eligible.  
We have seen a lot of activity about dual-eligible, which we will   
talk about later on. Had but lately there has been real interest in   
coordinating Medicare and Medicaid services, even to the point of   
integrating it under one budget, both the Medicare and Medicaid   
services.  
To that end, recently CMS offered states the option to come on   
board as a demonstration state for dual eligibles and to come up   
with strategies that integrate those two services. That will be   
rather exciting.  
So when we talk about dual-eligibles, that is one of the hot   
topics across the nation which we will be seeing more about. It is   
based on the idea that your Medicare silo is here, Medicaid silo is   
over here, the two don't coordinate cases together.  
So that will be exciting proposition. Hopefully in a couple   
years we will have a webinar on the success of the dual-eligibles.  
>> TIM FUCHS: The questions are really rolling in. Let's take   
one more from the web. If we don't have time during this break, we   
will certainly cover them before ending the call.  
Margaret asks: Concerning eligibility, what level or types of   
visual impairment will qualify? And do those qualifications apply   
at any age?  
>> SUZANNE CRISP: They do qualify at any age. I have used to   
work at the disability determination unit in the State of Arkansas.  
This is ancient history, but as I recall it was vision of 20/100   
that was not correctable.  
I know this is a poor job of this, but that is basically it. I   
know we can find out more information about that. In a note that   
will come to you all tomorrow, I will send information out on   
socialt security disability.  
  
There is something that helps handle the determinations for   
eligibility, and that will give you an idea. If somebody says they   
turned me done at social security, you can say what was your   
diagnosis? Let's look here and see what you need in order to   
qualify? I will send that out for you tomorrow. It will be a nifty   
thing  
>> TIM FUCHS: Folks, I see these questions coming in. Trust me   
we will do our best to get to them. Let's check and see if we have   
questions on the phone.  
>> HOST: Ryan has a question.  
>> Actually my name is Judy. Does every state follow the   
spend-down rule that they all adhere to allowing a spend-down for a   
consumer if they need Medicaid?  
>> SUZANNE CRISP: No, I am afraid that is optional. The state   
either has the option to recognize medically-necessary or not, and   
that is a shame.  
>> Thank you.  
>> TIM FUCHS: I will jump in here because there are a number of   
spend-down questions online. I will take the one that came in   
first.  
Pat asks what are the chances of changing the equation used for   
spend-down amounts? Many consumers are placed at poverty level due   
to high spend-downs? Any advice?  
>> SUZANNE CRISP: Oh, I bet. The spend-down is managed on the   
federal level, so it would take -- you know what, here I am going to   
say that I need to get back with you on this.  
I know it is an optional program, but I am not sure if the   
federal government or the state sets the spend-down limitations. I   
can easily look that up, and I may even be able to look it up while   
we're still on the phone today.  
But for sure I will answer the question tomorrow, but I do want   
to give you the right answer instead of a guesstimate.  
>> TIM FUCHS: Tim wonders about prosthetics being covered under   
either program, for example prosthetic eyes?  
>> SUZANNE CRISP: For Medicaid it would be under how medical   
supplies and DME. Again, that is an optional program. You would   
need to look at your state program to see if they did cover that.  
But the categories by which you would cover that would probably   
be home medical or DME category. At the end of this call I will   
give you a website. You can tap on your state and see its Medicaid   
program.  
It is a pretty simple way to see all the things that are covered   
or not covered within your state. Is will be a nifty little tool as   
well.  
>> TIM FUCHS: Let's see if we can fit in a couple more. Do any   
of the Medicare plans cover mental health services inpatient or   
outpatient?  
>> SUZANNE CRISP: I know that they do. Behavioral health and   
services, substance abuse and mental illness, it has become such a   
hot topic that if they don't cover it now, I bet they soon will.  
Specifically about what is covered under Medicaid, I will say   
that I will research it and get back with that person to outline   
what is covered.  
With Medicaid it certainly is covered. It can be a waiver   
service, an certainly there is a new authority that can be modified   
to cover behavioral health services strictly for individuals that   
want to live in the community, but you would also have to qualify   
for Medicaid.  
  
  
>> TIM FUCHS: One more time to the phone.  
>> HOST: No questions at this time. If you have a question,   
press 7 on your telephone keypad.  
>> Tim M FUCHS: I realize there are a couple we didn't get to,   
which we will address in the final Q&A toward the end of the call.   
I will now flip to Slide 21.  
>> SUZANNE CRISP: This slide is talking about home and   
community-based services. Here is where we finally get down to the   
things that matter most to us.  
This slide is just a high light of the various authorities that   
have been created for home an community-based services. We know   
that prior to 1981, only home health was provided in the home.  
Other than that if the person had a chronic need it was dealt   
with in an emergency room hospital or a nursing facility or ICMFR.  
In 1981 Katie Becket and her family took Medicaid to task. She   
had significant developmental disabilities.  
Her mother sought help for her. The state said if you   
institutionalize her we will pay for everything, but if you keep her   
at home we will pay for nothing.  
Katie's mother took exception to this and even appealed to   
president Reagan at the time.  
  
President Reagan said -- back then was called health financing   
care administration or HFCA, you will change the law to where people   
can have an option to either be serve in the community or their   
home.  
So they made it an option for states to follow. Just imagine   
where we would be if Katie Beckett an her family had not taken on   
such a strong advocacy role. Certainly it helped that she had the   
ear of the president.  
Later on, social security was added to allow section 1915 "a)   
voluntary managed care authority.  
  
We don't have many of those. I think there are one or two in the   
nation. But there are a lot of section 1915 (B) allowing for   
mandatory or voluntary managed care.  
And 1915 (C) allows those who would qualify for level of   
institutional care to receive services at home. Let's continue on   
with some of the federal authorities.  
Slide 21 and 22 can kind of be your guide for being all the   
various authorities. We will talk about each one of those quickly   
here. But do know that all these different authorities are out   
there.  
If a person says "waiver" you need to know the kind of waiver,   
what alphabet. Slide 22 shows we have state plan services which are   
basic services, both mandatory and option services that are not   
waiver services which anybody can receive if they have the medical   
need and are eligible for Medicaid.  
A minute ago we talked about the C waivers. Something new, the   
1915 "I" waivers. The 1915 J waiver is self directed option. The   
community first option which gets a lot of attention is the 1915 k   
created with affordable care ability.  
Then managed care authorities are "a" and B which we talked   
about, and section 1115 you might hear people throw around the term   
we will apply for 1115, and what does that mean.  
So this is your sheet for what all of them are, and it will   
explain and come closest to what you all do.  
State plan services are available to individuals on Medicaid and   
have the medical need for a service. Home and community-based   
services are usually considered personal care-type services, home   
health services, rehabilitative services, targeted case management   
and self-directed personal care.  
Again, if any of these services in your state -- these are all   
optional services. Remember that most optional services that meet   
the definition of home and community-based are optional services.   
It is an important political note for us to make.  
On the next slide we see how to receive a state plan service.   
The individual must be eligible for medical services under the state   
plan. They needs-based criteria must be established, meaning the   
state sets the level of medical need by which to be eligible to   
receive that service.  
  
The individual must reside in the community and have income that   
does not proceed 150% of the federal poverty level. The Affordable   
Care Ability allowed us to expand eligibility up to 300% of SSI   
eligible for some of our new waivers, which has all been an option   
for the 1915 (C) people.  
These are not in necessarily in all if a bet call order. I   
wanted to pick out the ones that would be most relevant. 1915 (C)   
allows coverage in a home-like setting which is now broadly defined   
as the home or apartment or an assisted living facility or group   
home, rest damagal settings.  
Know that CMS is looking at modifying and tightening that   
"setting" requirement.  
  
So we will be seeing some come soon from CMS. They have been   
saying "next few weeks" since last year  
States can set different geographic limitations. For example if   
they want to pilot a program in a geographic area, they can.  
Or if they have a strong provider group here and they don't have   
those kind of providers anywhere else in the state, they can just   
serve that one particular area while they develop a provider   
network.  
They can offer services to a particular group. For example,   
persons with disabilities would have a different service package   
than developmentally disabled or persons with TBI or traumatic brain   
injury.  
Here is where it talks about the use of the higher income   
ceiling. Because nursing homes allow a higher ceiling for income   
eligibility, the 1915 (C) amendment said we want to take on the   
same financial eligibility as a nursing home has. C that is 300% of   
SSI which is at $710.  
So annually that would mean that if a person had income of less   
than 25,560 dollars, that they might need the financial level for   
home and community-based services. That is substantially higher   
than the regular Medicaid program at 100 or 150% of poverty.  
The next slide shows 1915 (C) were intended to meet the rising   
demand for long term services and supports. More of us are entering   
long term services, putting a strain on that system.  
This can also serve, -- waivers can also serve diverse groups   
like people with autism or AIDS or people with substance abuse.   
Some refer to them as "little bow teek" waivers, but they can be   
directed to a small population group.  
  
1915 (C)s eye how for consumer-directed options. Currently there   
are over 300 waivers severing people. The primary waiver for   
individuals with significant disabilities are 1915 (C) waivers. In   
your state that is probably the most common waiver serving people in   
their homes  
The next slide I draw your attention to another waiver program   
called the 1915 (I) amending the state plan through the balanced   
budget act. Established in 2007.  
This is important in that it allows the states to offer home and   
community-based services without the link to nursing home care.  
For 1915 "C" people need to meet the level of care one would need   
to be admitted to a nursing home, which is pretty substantial.  
  
It requires substantial assistance with ADLs and IDLs and some   
skilled care. But with 1915 (I) states can create home and   
community-based services for people who maybe just need personal   
healthcare or a few home health services.  
At least seven states have applied for 1915 (I) programs to   
basically cover behavioral health or self-direction.  
1915 j might be familiar to you, the code application of the   
counseling program. In other words if you elect to have a 1915 j   
program, it will be a personal assistance services program that   
offers budget authority, the use of a budget in purchasing   
permissible goods and services, as well as the ability to hire your   
own staff to come into your home and provide personal care-type   
services.  
States may limit or target this program. I think there are only   
about six states operating in 1915 J, the largest being Arkansas.  
The 1915 K, a community first choice or CFCO as some call it.   
But it is a 1915 K.  
It was added with the affordable care ability act in 2011   
allowing community-based attendant care services.  
  
Federal government wanted people to take advantage of this,   
offering a 6% enhancement to the life of the Medicaid program. I   
didn't have time to initially cover this and I may not have time   
here, but the federal government supports state Medicaid program by   
matching services.  
In other words, states pay for half of their Medicaid program,   
and the federal government pays for half of their Medicaid program.   
So when you talk to your state, just realize that there is at least   
one-half of each dollar paid for by the federal government.  
In states that have less resources, states like Mississippi or   
Arkansas or Tennessee, the federal government pays an even greater   
amount, as high as 80% of the Medicaid program.  
Last I looked in Arkansas, it was about 75%. So keep in mind   
when state folks say we don't have money for this, remember they   
only have to come up with like one-third of the dollars.  
And with community-first option, they get an additional 6% on top   
of that. The only problem with community-first option it is   
targeted to individuals who meet level of care, so they have to be a   
person with pretty severe and chronic illnesses.  
More on community-first option. Basically it is attendant   
services, helping people accomplish daily living tasks. It can be   
hands-on supervisory or cueing.  
Some are hands-on only, so if a person has to be reminded or   
supervised while they perform the task, then they weren't eligible   
for that service. But quhun e first option recognizes supervising   
and cueing.  
It must be consumer-controlled.  
  
That means to the degree permitted and desired by the   
participant, that he or she has flexibility and control over the   
services and those that provide those services  
One thing that is very interesting, this authority requires the   
establishment of a development and implementation council including   
a majority of members with disabilities, elders or their   
representatives.  
I think this is where some CILS can come in handy with helping   
the state meet this requirement by bringing name in of advocates and   
persons with disabilities to derve on those boards.  
The next couple slides talk about -- no, the next slide. It   
talks about managed care. Apparently it is one of the new sexy   
things out there.  
Right now 16 states operate with Medicaid managed care program.   
By the end of 2014, another 14 states will have come on board with   
managed care.  
Basically, managed care is a system where an either for-profit   
home health plan or a not-for-profit home health plan contracts with   
the state to provide particular services, waiver-type services. The   
state pays that entity a capitated or per member per month rate.  
So whether you use the service or not, that managed care entity   
does receive that rate.  
If you are a high user, the managed care entity probably loses   
money on you. If you are not a high-use person, the managed care   
entity probably gains a little profit there.  
The authority by which you can manage care include 1915 i and b   
and an 1115 demonstration. Let me see what else I need to say about   
that.  
Typically the c and i and k are for fee-for-service, you receive   
care for an hour and you have a flat fee. So there are the two   
different funding types, fee-for-service and then the capatative   
managed care rate.  
1115 managed care program, some states are redesigning program as   
to not be so complex to have a waiver here and there and an   
authority here and there.  
They are looking at the program saying we want just one program,   
one set of quality assurance and improvement mechanisms, one   
eligibility, one provider enrollment process.  
States like Vermont and California and I believe that Florida is   
attempting to develop an 1115, as well as Minnesota. So instead of   
all the thing we have talked about, this is going to be one program   
under a demonstration project.  
What the state does here, it creates this big structure for   
managing their Medicaid program, and it goes to the federal   
government and says we want to waiver certain things, like we don't   
want this about C so we want to waive that, or we don't like this   
about the i so we want to waive that, kind of like a create your own   
program.  
  
We are seeing more states now considering that. In the past the   
1115 was used for things like the cash and counseling demonstration   
or prescription demonstrations.  
We are nearing the end. Let's talk about dispute resolutions.   
All states must offer a fair hearing. If you qualify for a fair   
hearing if you are not given the choice of home and community-based   
services, if you are denied services of your choice, and if you are   
denied freedom of choice of providers.  
And you are eligible for a fair hearing if you are denied   
services, suspended services, or if your services are reduced or   
terminated. Each state will have a fair hearing process, which I   
will talk about how to find it in a second.  
Some states, we know they have to offer fair hearing systems and   
processeses but also they offer grievance and complaint   
opportunities that are less formal.  
You can say I didn't like this and I want to tell somebody what I   
didn't like, and I want them to talk to me about how we can correct   
those things.  
Some states have those things, some states don't. In order to at   
this point out more about your Medicaid program, we are going to   
give some resources via an e-mail tomorrow.  
The e-mail will also include answers to some of the questions   
could not answer today. In you access www.medicaid.gov it will   
bring you to the CMS website.  
As we know, the CMS website has Medicare information and Medicaid   
information. So you would want to click on Medicaid, and it will   
take you to a link that has a map, and you can click on your state   
and it will tell you or give you examples of the waivers in your   
states.  
It will also lead you to where you can find additional   
information actually on the state website. The website is new and   
improved. Let's say a year ago, the medicativment d.gov website was   
must e, confusing.  
But this redesigned website awfully nice, and I invite you to   
look at it. You click on Medicaid and you will get into the system   
and you will probably be amazed at what you find there.  
I see Tim has just put the web address on the web that are   
screen. I think that leads us to questions. Sorry it got a bit   
rushed there.  
>> TIM FUCHS: Know problem. Amanda will give the instructions   
for those on the phone one more time, and then I will begin with the   
few questions we didn't get to on our last break.  
>> HOST: If you have a question, press 7 on your telephone   
keypad.  
>> TIM FUCHS: I believe some of these are quick. Ron wonders if   
you can elaborate more on nursing home payments that come from the   
state.  
>> SUZANNE CRISP: We know that nursing home is a required   
service under the Medicaid state plan, and we also know that   
depending on your medical assistance rate, the federal government   
pays a portion of the fee.  
So let's say you are in California and you are a rich state and   
you are what they call F-MAP or medical assistance participation   
rate of 50%.  
The rate that the nursing home would be paid t would be partly by   
the state and partly by the federal government. If you were in   
Mississippi, the amount would be substantially more that would be   
paid by the federal government.  
As far as rate-setting, that is probably a topic for another day.   
I would not be the person to do that. Rate setting for nursing home   
is a state function. It isn't tied to Medicaid rules or   
regulations. Medicaid simply says it has to be adequate and   
sufficient, and the state then negotiates the rate of pay with the   
nursing home lobbyists, with lj lay chrs and a number of other   
things. It does get to be a long, involved question.  
  
You may find information about your state if you follow the   
websites adjust gave you.  
>> TIM FUCHS: Thanks. Here is the million dollar question from   
Melinda: Why is it that home and community-based services are still   
considered optional when they are cheaper than nursing services?   
Why is it so hard for us to change that?  
>> SUZANNE CRISP: Great question. It is the 64,000 dollar   
question. We know back in 1965 they created this thing called   
Medicaid.  
At the time I am sure certain lobbyists and people were   
pressuring the federal government on what or what not to include,   
and nursing home lobbyists were probably there.  
But it got into the law where it said nursing home services are   
required under the state plan. We know in 1981 was the date e   
Becket waiver, then the 1915 c waivers came to pass.  
But waivers are still considered optional.  
  
It would take a change in the constitutional law, social security   
ability, to make home and community based services mandatory. That   
is what it would take, and apparently that is just harder than the   
dickens to do, because we sure haven't made much headway  
>> TIM FUCHS: We will keep working on it.  
>> SUZANNE CRISP: I will say that early on, like in the 1990's   
it used to be that nursing homes were paid 80% and home and   
community based services were much less.  
Now in many states it looks more like a 50/50 proposition. In   
other words, 50% of Medicaid funds go to nursing homes, and 50% of   
Medicaid funds go to home an community-based services. So we are   
making a dent.  
>> TIM FUCHS: Let's see if there are any questions on the phone.  
>> HOST: The first question, go ahead.  
>> I am Daniel from St. Louis. My question concerns intermittent   
catheters. I myself and several participants use closed-system   
intermittent catheters, and as you are surely aware we are no longer   
finded by Medicare Medicaid.  
Can you provide insight about why it is now necessary to be on   
straight cats with two documented urinary tract infections before   
they realize it is a necessity?  
>> SUZANNE CRISP: I don't, but I will be happy to research this   
for you, Daniel. Hopefully I can get to that research tonight and   
get you an answer.  
Just superficially, it doesn't sound like it makes much sense,   
then again we are dealing with the federal and state governments.   
Let me do some research.  
>> Thank you.  
>> TIM FUCHS: One more phone question.  
>> Go ahead. Hello? You want me to ask the question?  
>> SUZANNE CRISP: Yes.  
>> I am Bob from Life Incorporated. I heard you say you needed   
to amend the social security act. I never knew you would go to a   
child advocate to make those services mandatory. Have you got any   
suggestions about the best approach to start or attack that?  
>> SUZANNE CRISP: No.  
>> Let me add this. The reason I say that, Medicaid is different   
in each state. The only way for it to be mandatory across the board   
is through the social security act?  
>> SUZANNE CRISP: Correct.  
>> Okay. That is why I am asking.  
>> SUZANNE CRISP: Amending the social security act is the only   
way I would know of because the social security act does create   
Medicaid.  
  
It specifies what is hand tore e, what is optional. How to get   
that done, if we haven't done it by now, we may not be able to do   
it. (Mandatory)  
  
in other words, I don't know what the impediments are, other than   
the nursing home lobbyist and whatnot. I think when we had the   
Ohmstead Decision, it was a huge push for home and community-based   
services  
Keep in mind that is a law that says you have to make them   
available. So in essence, it is almost in the law, but it is just   
not well-protected.  
In other words, if a state had budgetary issues and they said   
we're going to get rid of all our optional services, they could get   
rid of home an community-based services.  
But then they would still have Ohmstead, which is a law. We know   
that more and more furpding is being channeled to home and   
community-based services.  
We know that less money is being channeled to nursing home, and   
we snow that home and community-based services are protected by   
Ohmstead. I am not sure we on necessarily need to change the law.  
I think it would be a good thing to do, but I don't know it is   
that critical. Just because of the Ohmstead law.  
>> The law being there and the option being there, they have the   
option to where it is so hard to get it all the way over, bend all   
the way over to pick up something. The option is there.  
>> SUZANNE CRISP: That might be a good webinar for Tim to have   
sometime, or a good open discussion of what are the pros and cons of   
doing this and how do we actually do it?  
The simple thing is to contact your Congress person. I would   
think there has been a strong, strong advocacy forces that are doing   
that.  
  
Sorry, but that is the best and I have  
>> Thanks for taking the question.  
>> TIM FUCHS: Thank you, Suzanne and Bob. We are just about out   
of time. I will try to fit in these last couple questions. One of   
these was about dual-eligibles, so let's move on to this.  
I know you wanted to follow up by e-mail about spend-downs, but   
Margaret asks you to elaborate just a bit for spend-downs for those   
who are overincome, to help her understand that.  
>> SUZANNE CRISP: Yes, and tomorrow in writing I will do a   
better job, I'm sure.  
A spend-down, if a person has large medical bills and their   
income is over the level for eligibility with Medicaid, they can   
still come into the Medicaid office or the county office and file an   
application for Medicaid spend-down, saying that they have -- what   
the caseworker will do, they will calculate their income and how   
much the income is over the amount of eligibility.  
And then they will start reducing that "over condition amount by   
their medical bills. And then once that person gets to the   
threshold of eligibility, it is on that date that they are   
Medicaid-eligible for a period not to exceed three months.  
  
So everything that falls on that bill date and beyond is payable   
by Medicaid. It isn't a perfect application process at all. I used   
to do those when I was a case worker in Arkansas  
And we don't know for sure if your state actually does have   
spend-down, Margaret. But that would be the process they would use,   
spending down all the income they are over in order to qualify for   
Medicaid.  
>> TIM FUCHSis: Thank yous, Suzanne. One quick thing with   
regard to your eligibility slide, somebody asked if you can quickly   
define "medical need".  
>> SUZANNE CRISP: Yes. Medical need would be the criteria by   
which the state approves you.  
We know that visually impaired is a qualifying event. Also to be   
eligible for social security disability, a person would have to meet   
the level of social security disability, regardless of whether or   
not they drew social security.  
So if you were a disabled person and you weren't eligible to draw   
SSI, you would still need to go through the eligibility   
determination process for the medical determination.  
In other words, if you are an adult and you are not a mother of a   
child on TANF, you would qualify with your disability.  
And the Medicaid agency uses the same criteria as the social   
security disability determination unit to establish your medical   
eligibility.  
So we have eligibility into the program, and then we have   
"medically necessary" which is once on the program, you have to   
medically need personal care.  
Like if I were on Medicaid and I were healthy but I just thought   
I would like to have some personal care or something, you just can't   
get that because you need to be medically-eligible to receive   
personal care.  
It is usually criteria like you must have assistance in two ADLs   
and one IDL to meet the medical necessity of personal care.  
>> TIM FUCHS: Thanks for the explanation. I an operating on   
borrowed time, but if you will indulge me, maybe we have time for   
one more question over the phone.  
>> HOST: No questions in the queue.  
>> TIM FUCHS: Great, we did get to everybody's questions.  
Slide 35, this is the evaluation form. This is the end of our   
content for today. With that I will close the   
call today. Thanks for being with us.  
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