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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