



New Community Opportunities Center Presents...

Effecting Policy Change in Medicaid and Community Services

February 13, 2013

3:00P.M. – 4:30P.M. EST

Presenters:

Suzanne Crisp

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Public Input and Government

- A requirement of the Federal Administrative Procedures Act
- Reduces conflict and litigation
- Impacts outcome of legislation
- Distributes expertise
- Improves the product

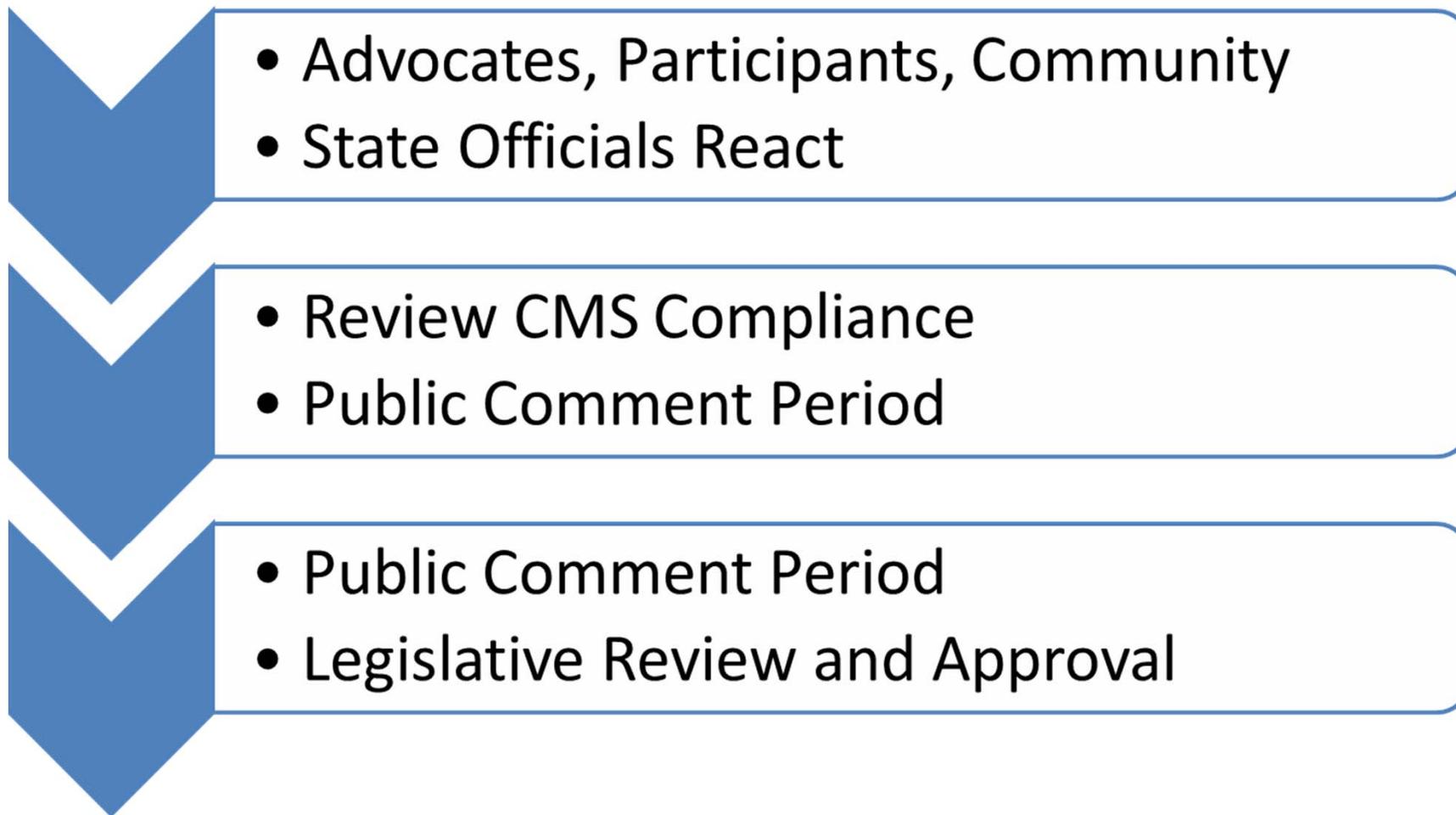
Federal Regulations

- Notice of Proposed Rule Making (NPRM)
- Interim Federal Rule with Comments
- Final Rule

Federal Policy Guidance

- State Medicaid Directors Letter
- Letters to State Officials
- Information Bulletins

State Process





See DEHPG Organizational Chart

Questions??

- Use the chat window on your screen to type in your questions.
- Or press the number 7 on your telephone keypad to signal the operator.

Federal Authorities

- Medicaid State Plan Services
- Medicaid Home & Community Based Services (Waivers) 1915(c)
- Medicaid HCBS 1915(i)
- Medicaid HCBS (Self-Directed Option) 1915(j)
- Community First Option 1915(k)
- Section 1115 Demonstrations
- Medicaid Managed Care Authorities
 - Section 1915(a)
 - Section 1915(b)

State Plan Services

- Some HCBS services are available in the regular State plan:
 - Personal Care
 - Home Health (nursing, medical supplies, appliances, home health aid, etc.)
 - Rehabilitative Services
 - Targeted Case Management
 - Self-Directed Personal Care

To Receive State Plan Services

- Must be eligible for medical assistance under the State Plan
- States must provide needs-based criteria to establish who can receive the benefit
- Must reside in the community
- Must have income that does not exceed 150% of the Federal Poverty Level
- Affordable Care Act – states have the option to include individuals with incomes up to 300% of SSI and eligible for a waiver

Section 1915(c)

- Provides an alternative to institutions
- Currently the primary vehicle to offer non-institutional services to individuals with significant disabilities
- Allows for consumer-directed options
- States may set geographical locations
- Offer different services to particular groups

Section 1915(c), cont'd.

- Serves individuals in a home or “home-like” setting (but the definition of “home-like” may vary)
- Income – may use the higher income ceiling (300% of SSI) and spousal impoverishment rules
- Must be budget neutral but can use different approaches to this
 - Individual budgeting
 - Aggregate budgeting
 - Mixed approach

Section 1915(i) State Plan HCBS

- Established in 2007
- Allows states to offer HCBS as a state plan benefit
- Breaks the “eligibility link” between HCBS and institutional care
- Most states use this option to cover behavioral health services
- Consumer/self-direction may be an option

Section 1915(j)

- Effective 2007
- Allows states the option to provide consumer/self-directed personal assistance services (PAS) in the Medicaid State plan
- May include permissible purchases
- Participants set their own provider qualifications and train their providers of PAS
- Must provide employer and budget authority
- States may target and limit

Section 1915(k)

Community First Choice Option

- Affordable Care Act added new option in 2010
- Allows states to provide a “person-centered” home and community-based attendant services and supports
- Individuals must meet institutional level of care (Nursing Facility, ICF-MR, IMD)
- States will receive 6% in federal financial participation

Section 1915(k), cont'd.

- Provides assistance with accomplishing
 - Activities of daily living
 - Instrumental activities of daily living
 - Health related functions
- Assistance provided through hands-on support, safety monitoring, and cueing
- All services and supports must be consumer-controlled
 - Agency-provider model
 - Self-directed with budget model
 - Other

Section 1915(b)/(c)

- Combines two authorities
- Section 1915(c) – typical Home and Community-Based Services offerings
- Allows state to overlay voluntary or involuntary managed care practices
- Michigan operates largest B/C
- Trend has been to use the Section 1115 authority

1115 Demonstration Projects

- Used when states seek to demonstrate whether a new service or intervention would lead to a change in Medicaid policy
- The Secretary may waive compliance with any requirement under 1902 of the Social Security Act
- Many states are using this authority to manage their entire Medicaid program

Dual Eligible Demos

- State Demonstrations to Integrate Services for Dual Eligible Individuals (Medicaid/Medicare)
- Person-centered models that coordinate primary, acute, behavioral and long-term supports and services
- 15 states selected: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin
- Get more info at: <http://ly.adapt.org/duals>

Where do I start?

Find out about the waivers in your state.

CMS has a webpage where you can see:

- Section 1115 Research & Demonstration Projects
- Section 1915(b) Managed Care Waivers
- Section 1915(c) Home and Community-Based Services Waivers
- Concurrent Section 1915(b) and 1915(c) Waivers

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>

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What is CMS telling the states?

READ IT FOR YOURSELF!

CMS issues guidance in the form of letters to State Medicaid Directors, letters to State Health Officials, and Informational Bulletins to communicate with states and other stakeholders regarding operational issues related to Medicaid.

(Tip: Search "Olmstead")

<http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html>



You can't fight City Hall!
So changing CMS must be impossible...

That's WRONG!
We *CAN* change CMS!

Example 1: Changing the MDS

The Minimum Data Set (MDS) tracked the number of people in nursing facilities that expressed an interest in returning to the community...

but NOTHING was done with that information!

ADAPT changed that!

Now when an individual expresses an interest in returning to the community they are supposed to be referred for assistance.

Examples of MDS Change

CMS created a brochure for NF residents about returning to the community. It explains to the resident why they are being asked by facility staff whether they want more information about the possibility of returning to the community.

<http://www.medicare.gov/publications/pubs/pdf/11477.pdf>

Is the MDS change working?

If you aren't sure what the process is in your state, ask the State Point of Contact!

Here's a link you can use to find that person.

<http://www.Itcombudsman.org/sites/default/files/issues/LCA-Point-of-Contact%20List-Final2-Portrait.pdf>

Example 2: Public Comment

States were making massive changes in their Medicaid programs without advocates even knowing about it. There were no public comment requirements for 1115 demonstration programs.

ADAPT changed that!

A final rule, effective on April 27, 2012, establishes a process for ensuring public input into the development and approval of new section 1115 demonstrations as well as extensions of existing demonstrations.

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How can I make comments?

CMS has a web page for that!
Seriously.

Here's yet another really long link you can use.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/public-comments.html>



I don't have 500 people willing to storm the HHS building in Washington.

What can I do?

Even without 500 activists, you *can* make a difference.

Bring the national work home.



Nationally, we have fought to get the Aging and Disability Resource Centers to include the Centers for Independent Living.

In New York, we have scuttled the state's application for ADRC funding and raised concerns regarding an 1115 waiver application because CILs were not adequately involved.

New York just applied for the Balancing Incentive Payment Program and described incorporating the CILs in its "No Wrong Door" system. Twice!

Five things advocates can do...

1. Participate in the public comment process.
2. Question state policy changes that promote institutionalization or undercut self-direction.
3. Ask the state how it is proactively supporting people in returning to the community from institutions.
4. Learn what other states are doing and ask why those best practices aren't being done in your state. Use the State Medicaid Director letters!
5. Demand that managed care have consumer protections and use contract language/rates that promote community living.

Ask questions of CMS

When your state tells you...

“CMS told us we had to do it this way.”

Ask CMS.

Then close the loop with your state.

In New York, by doing this, we were able to be on the call where CMS was giving guidance to the state about implementing the Community First Choice Option!

You don't need to do it alone...



- Find and work with experienced Medicaid “wonks” in your state.
- Join (or START) a My Medicaid Matters Coalition! You can get ideas here: <http://www.mmmmtx.org> and http://www.adapt.org/main/medicaid_rally
- Get involved in ADAPT. <http://www.adapt.org/main.training>
- Learn from other CIL and ADAPT advocates. Many of us are happy to help. You can reach me by email at BDarling@cdrnys.org

Finally, a homework assignment



If your state has NOT selected the Community First Choice Option*, ask the state to do a formal analysis to determine whether it should. Insist they “show their work”.

Need help?

With just three links, you are a CFC expert!

<http://ly.adapt.org/cfcoverview>

<http://cdrnys.org/files/CFC-FAQ-122211.pdf>

<http://adapt.org/main/cfcletter>

*Arkansas, California, Louisiana, Maryland, Minnesota, New York, Rhode Island, and Washington have either selected or announced they are selecting CFC.

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Wrap Up and Evaluation Survey

Your opinion counts! Click the link below to provide your evaluation of today's webinar:

<https://vovici.com/wsb.dll/s/12291g52608>

For more information

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New Community Opportunities Center at ILRU



This program is part of a series of trainings and other activities provided to the IL field by the New Community Opportunities Center at ILRU. The project's purpose is to assist CILs in developing self-sustaining programs that support community alternatives to institutionalization for individuals of any age, and youth transition from school to post-secondary education, employment, and community living. ILRU's partners and collaborators in the project include:

- Utah State University, Center for Persons with Disabilities
- National Council on Independent Living
- Suzanne Crisp, national community alternatives expert
- Association of Programs for Rural Independent Living
- Michele Martin, Social Media Consultant

New Community Opportunities Center

Attribution

This training is presented by the New Community Opportunities Center, a national training and technical assistance project of ILRU, Independent Living Research Utilization. Support for development of this presentation was provided by the U.S. Department of Education, Rehabilitation Services Administration under grant number H400B100003. No official endorsement of the Department of Education should be inferred. Permission is granted for duplication of any portion of this slide presentation, providing that the following credit is given to the project: Developed as part of the New Community Opportunities Center at ILRU.