# CMS Responses to Questions from the International Self-Determination Conference – Detroit, 2008
**October 20, 2008 DRAFT**

## Federal/State and Self Determination:

1. **Is CMS organized by region? How do I find out who within CMS is looking at California's self-directed services and can stakeholders contact them?**

   CMS is organized into 10 regions, along with the Central Office in Baltimore, Maryland. California is located in Region IX. Each program within Medicaid has a CMS Central office and Regional Office contact. The CMS web site, at www.Medicare.gov lists the office numbers for the Regional Offices and the Central Office.

2. **One of the biggest obstacles I see in my State is the issue of siloed funding. Wouldn't it make sense for CMS to encourage each State to look at Medicaid Self-Determination waivers as a way to reduce management costs of multiple programs when this could be as one size fits all option? More education needs to come from the top (CMS) down (providers) through State agencies. I keep hearing as an advocate that Medicaid is moving away from nursing home/institutional care to more self-directed in-home care possibilities yet the providers who serve my elderly mother insist that they know nothing about that. What is being done to educate State agencies and providers about these options? And how can consumers be more empowered to drive these changes?**

   We appreciate your input on the need for more information and education about CMS' self-direction programs and options. We try to highlight the self-direction programs at every feasible opportunity, such as the Home and Community Based Services conference, but acknowledge that more work needs to be done to educate State Medicaid Agencies, other State agencies, providers of services and supports and consumers. We are currently investigating additional ways to develop and distribute technical assistance products to States, such as papers and presentations at conferences. We welcome specific recommendations and strategies.

3. **If self determination is funded by the U.S. government, why doesn't the individual contract directly with the U.S. government rather than the "trickle down" through the State and/or county level where there is more chance for misinterpretation of rules/laws/guidelines?**

   Direct contracting between the Federal government and individuals is not allowed under current law. The provisions of Title XIX of the Social Security Act dictates that the Medicaid program is a shared funding program between the Federal government and State governments (including DC and the territories) to provide health care to certain categories of eligible individuals,

as well as certain low-income eligible individuals. Self-determination and self-direction are models of service delivery that could be funded with Medicaid dollars (a combination of Federal and State dollars), State-only funds or other revenues. The Federal Government is required by the Social Security Act to enforce the provisions of the Medicaid program in partnership with the States. States implement the programs with service providers and Medicaid recipients.

4. **When, if ever, does CMS expect to require self-directed options are available in all States?**

   Currently, CMS does not have the authority to mandate or require States to adopt self-directed delivery models. We cannot predict when, or if, we would make it mandatory in all States. In the meantime, we encourage States to establish self-directed programs, and we are available to provide technical assistance to States to facilitate implementation of these programs.

**Comparability/Consistency:**

5. **Why can't all services be offered across the disability groups/coalitions to prevent fragmented services, competition between labeled groups for funding and throughout State regions (urban vs. rural)?**

   Medicaid, by statute, is a Federal/State partnership. It is structured in such a way that States receive Federal financial participation for expenditures for services at different rates depending on their per capita incomes. That rate is called the Federal Medicaid Assistance Percentage (FMAP). The Federal government bears the costs for States' Medicaid services at the FMAP rate, and the States would bear the remaining costs for their Medicaid services. For example if a State's FMAP rate was 70 percent, the Federal government would bear 70 percent of the costs and the State would bear 30 percent of the costs. Additionally, States are only required to provide a subset of all the possible services available for Medicaid funding. The limitations imposed by State budgets often mean States must make difficult decisions regarding which optional services they will provide.

   Creating a Medicaid system that would require all possible Medicaid services to be provided to all populations in all States would require a major legislative change.

6. **When local governmental money is used as a match that causes inequity of resources based on demographic regions, how does CMS evaluate comparability?**

The issue of differential access based on variation in levels of funding across counties could create problems of comparability or of Statewideness. Comparability is covered under section 1902(a)(10)(B) of the Social Security Act and means that the services available to one group of "categorically needy" individuals (e.g., poverty-related children) as compared to another group of categorically needy individuals (e.g., elderly SSI recipients) must be the same in amount, duration and scope. ("Categorically needy" groups are those that the State must cover and who qualify for the basic mandatory package of Medicaid benefits. States may also elect to offer services to "medically needy" individuals that are not the same as those offered to the "categorically needy". However, services available to any "categorically needy" recipient must not be less in amount, duration and scope than those services available to a "medically needy" recipient") In other words, under the State Plan, States may not limit services based on the categorical status of an individual (e.g. women, people with certain conditions, age, etc.) Statewideness is covered under 1902(a)(1) and requires that States electing to participate in Medicaid must operate their programs throughout the State and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. Statewideness is an assurance by the State that all eligible people will have reasonable access to Medicaid services. We do not currently have established standards against which to judge what would be considered adequate coverage for Statewideness to have been met. For instance, if services are available only in a large city but not the surrounding counties does that meet the intent of the Statewideness requirement? Could there be instances where services providers are not willing to work in some geographic areas (e.g. rural, or inner city)? Should there be increased rates or other incentives in place to make sure there is coverage available in all areas of the State? These are a few of the questions that would need to be considered in order to develop effective policy. Some questions may require statutory changes to address, others could be effectively addressed through regulations or other administrative policy vehicles such as State Medicaid Directors Letters.

7. **Is Medi-cal (California's name for its Medicaid program) operated the same way as Medicaid in other States i.e. a State medical agency with an advisory committee and a regional oversight? Can you make a model set of policies so any advocate can do the work of preparing any of these applications to work with our State agencies?**

   Yes, each State's Medicaid agency must adhere to the requirements of the Federal Medicaid program. There are numerous requirements for States who participate in the Medicaid program, including a minimum required set of services and supports that States must provide. For a summary of these requirements see the document Medicaid At-a-Glance: http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2

005.pdf. There is a requirement that States have a medical advisory committee (see section 431.12 of Title 42 of the Code of Federal Regulations for details) that must include members of consumers' groups, including recipients, and members of consumer organizations.

**Mental Health:**

8. **Why is there a disparity between programs for Mental Health and other populations? How can all these changes (self determination) be implemented when one can only see a psychiatrist once every three months for fifteen minutes? How can there be effective psych rehab day programs when the Federal/State Medicaid budgets decrease to the point that programs cannot retain good employees?**

   There may be many reasons for disparities and limits to services. First, in order to participate in the Medicaid program, States must agree, among other things, to provide a core set of basic Medical services to all Medicaid eligible recipients. However, many mental health services, particularly recovery oriented services, are not required by statute to be offered by States. States may choose to offer such services, but not all States do. This is often due to a host of factors, including limited State budgets, lack of awareness of the benefits of comprehensive mental health services, disconnects between State mental health departments and State Medicaid Agencies, and ineffective advocacy. While CMS encourages and supports comprehensive community based mental health services that promote recovery, we cannot at this point mandate that they be provided in every State.

9. **Which States have been able to define community integration as medical necessity for mental health Medicaid funds?**

   Medical necessity as defined by States can be significantly focused on community integration rather than a strict medical model. For instance Michigan has a very inclusive definition of medical necessity that includes the services "designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence recovery, or productivity." It is important to remember that a State's definition of medical necessity cannot force Medicaid coverage for services that are beyond the limitation set in statute. Conversely, States may set Medicaid criteria that are less than the full array of possible community based services and supports. States use several mechanisms to limit services including the following:
      a. Limiting services to specific geographic areas such as a particular county
      b. Limits on who may receive services based on age, disability type, and other factors

c. Limits based on level of need (e.g. restricting access until an individual is ill enough to be placed in a nursing facility)
d. Limits on the scope of services offered
e. Deciding not to cover optional service categories such as particular services under the rehabilitation option.

These mechanisms are decided at the State level. CMS does provide incentives, primarily through our grant programs, to encourage State to develop more comprehensive programs. However, requiring a comprehensive set of community based supports and services would require legislative change.

**10. Why don't state plan amendments (SPAs) offer services to mentally ill?**

Actually, there are several SPA authorities under which States may provide mental health services. In addition to physician services and inpatient services that are required for all Medicaid recipients, the rehabilitative services option under section 1905(a) of the Social Security Act is used extensively by States to provide recovery oriented services such as Assertive Community Treatment, psychosocial rehabilitative services, individual/group therapies, and other evidence based practices. Additionally, more States are using the rehabilitative services option to develop peer support programs. Finally, we are beginning to see States create supported employment programs that braid funding from vocational rehabilitation and Medicaid. These kinds of innovative approaches are leading the way to breaking down the silos of care between different Federal and State agencies.

**11. How do systems ensure that Medicaid services become recovery-based without people losing needed services throughout their individual recovery periods or their life spans? How does CMS define "recovery"? Does recovery mean "cure" to CMS?**

We support the definition of "recovery" from the final report of the President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America: "Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."

We are aware that recovery from mental illness is often a non-linear process with ups and downs along the way and as a result the need for services increase and decrease accordingly. There are no Federal limits imposed on the amount and duration of services and we fully support access to necessary services to people wherever they are in the recovery process.

12. **Is the ultimate goal to have self-direction be the rule in the mental health world? Is there a timeline to how long before we would get there?**

    We support self-direction and self-determination to the full extent allowable under the statute and rules governing Medicaid for all populations. We hope that States will offer self-direction widely to people with psychiatric disabilities. However, because Medicaid is a State/Federal partnership with each State determining their programs and optional services and populations, it is virtually impossible to determine how long it may be for States to fully implement self-direction for people with mental illnesses.

13. **I am from Arkansas and I am an advocate for those of us with psychiatric disabilities. What do we need to do to get our group covered? It has been hard getting access to self direction.**

    There are options under several Medicaid authorities for self-direction. These include section 1915(c) Home and Community-Based Services (HCBS) waivers, section 1915(b) Freedom of Choice waivers, section 1915(i) HCBS State plan option, section 1915(j) self-directed Personal Assistance Services State plan option and possibly the Medicaid Benchmark Option under section 1937 of the Social Security Act. Understanding and using these authorities is a complex undertaking, and your CMS Regional Office can help you to determine the best options available for self-direction.

**Housing:**

14. **Tell us more about section 8 home ownership vouchers. Who can get these? How does one apply? Are there income caps?**

    The Department of Housing and Urban Development (HUD) administers the Section 8 Home Ownership Voucher Program. The HUD website provides extensive information on the home ownership voucher program, and is located at:

    http://www.hud.gov/offices/pih/programs/hcv/homeownership/index.cfm

15. **Can a section 8 program cause you to lose your SSI benefits? Can you get a grant for transportation to work if you have a job?**

    Housing assistance is not counted as income under the SSI program. The Medicaid State Plan transportation service is an optional service that a State may select to cover; and if it does, the service is usually reserved for trips to medical services. However, transportation destinations can be expanded under Home & Community Based waivers. Your State Medicaid Program could

advise you if this service is covered under the State's waivers and if the limits of this service include transportation to work. Also, under the Demonstration to Maintain Independence and Employment (DMIE) administered by CMS, some State grantees plan to use their grant to fund non-emergency transportation for grant participants with potentially disabling conditions. Other Federal agencies, such as the Department of Transportation, may provide grants to States for this purpose as well.

**16. Is there a cap on how much Medicaid will reimburse or budget for support persons for individuals in their own homes?**

There is no Federally-imposed cap on the amount paid for supports or support persons for people who live in their own homes. The amount Medicaid will reimburse or allow in a self-directed budget for providers of services and supports, will be limited by what the individual is determined to need and also what the individual wants to accomplish in order to have full access to community life. This may also be limited by the State's overall budget that is available for services to a particular population. So, while CMS does not mandate a cap on self-directed services, the reality is that the State has limited Medicaid dollars to spend. That is why it CMS is exploring more opportunities for "braided" funding (i.e., the individual's wants and needs are funded from different agencies, but separate audit trails are maintained) and even "blended" funding (i.e., the individual's wants and needs are funded from a blending of funds from different agencies and there is no need for a separate audit trail.)

Under a 1915(c) program, a State must assure that the costs for the services provided through a waiver do not exceed the costs to serve the same population in an institutional setting. States have a great deal of flexibility in how to meet this "cost neutrality" test, so it is important to contact your State Medicaid Agency to learn any particular limitations that may apply to a waiver in your State.

Also, as a reminder, Medicaid is statutorily prohibited from paying for room and board in home and community based services.

**17. How can we increase the number of subsidized housing available? We need more homeless shelters urgently!**

The HUD Homeless Resource Exchange has a great deal of information on funding for housing programs that serve persons who are homeless. Please see http://www.hudhre.info/

18. **Concerning preventing impoverishment: Rent assistance programs currently available under State Medicaid plans as State supplement cash assistance doesn't come near to meeting rent levels or the cost of food. Can CMS help with rental assistance efforts? We understand now that we cannot use waiver dollars for rent or food assistance. In the future could we use waivered funds to help people pay their rent and food? Maybe through Section 1915 (j)?**

    Currently, assistance with rent or food costs (room and board) is not allowed under Medicaid. Sections 1915(c), 1915(i) and 1915(j) of the Social Security Act all include specific language prohibiting the use of Medicaid funds for this purpose.

19. **Need more affordable housing -- non-segregated housing. Housing cannot be tied to support services -- people need to be able to control who comes and goes through their front door. Many subsidized housing options are segregated and people are "trapped" in the projects as their support is tied to the building, not tied to the person.**

    Through the Money Follows the Person Demonstration Program, CMS is looking to ensure that housing (not tied to supports) is among the options promoted through collaborations with HUD and the Grantee States.

**1915 (i) and (j) State Plan Options:**

20. **Can the 1915 (i) waiver support partial hospitalization (and the other exceptions for chronic mental illness) to Medicaid only recipients?**

    1915(i) allows States to offer any of the services indicated under 1915(c)(4)(B) of the statute. The following services for persons with chronic mental illness are among the services listed under the statute: day treatment or partial hospitalization, psychosocial rehabilitation, and clinic services.

21. **Currently, services are limited for persons with mental illness. This excludes a significant number of SSI recipients who need these services. This is a major gap in service. How do we encourage our State to apply for a 1915 (i) waiver?**

    Contact your State Medicaid Agency to express your support for the submission of a 1915(i) State plan option. We encourage you to provide specific suggestions on services to offer through the program, and how those services can benefit persons with mental illness.

**22. 1915 (i) allows consumers to hire what are referred to as "responsible individuals" to work as providers of care. Who can advocates contact regarding applying a pressure to States to get them to do this?**

In their request to amend their State plans to add 1915(i) services, States must define in writing standards for providers (both agencies and individuals) of home and community-based services. Contact your State Medicaid Agency to express your thoughts about the importance of allowing this flexibility in the State's program design.

**23. So 1915 (i) still requires people to be in poverty?! (150 % FPL)**

The statute requires that applicants for 1915(i) State plan HCBS must have income that does not exceed 150 percent of the Federal Poverty Level (FPL).

**24. My State is telling me they are subject to an upper payment limit in the (i) and (j). Is this true?**

The Federal Medicaid program has not imposed an "upper payment limit" in the section 1915(j) self-directed personal assistance services (PAS) State plan option nor 1915(i) State plan home and community based services (HCBS).

Under the section 1915(j) and 1915(i) State plan options, an assessment of the individual's needs, strengths and preferences is completed and a person-centered plan is developed that is individually tailored to meet those needs, strengths and preferences.

For the 1915(j) services, the individual must be told the amount of the budget they will be receiving before the person-centered plan is finalized, so the individual can then plan how they will spend the budget allocation. CMS is aware that States have budgetary limitations and use different planning approaches for determining the budget amount. However, we require that whatever planning approach is used, the budget methodology must ensure that the budget allocation for all participants is objective; evidenced based; utilizes valid, reliable cost data; is applied consistently to participants; is open to public inspection; and includes a calculation of the expected cost of the self-directed PAS and supports, if those services and supports were not self-directed. As persons eligible for self-directed PAS must already be eligible for and receiving the optional State plan personal care services benefit or services in a section 1915(c) waiver, the amount of the funds available to a participant for their self-directed PAS "budget" is not to exceed the amount that the State would pay for the services and supports if those services and supports were provided under the traditional service delivery model.

We believe that there are sufficient standards to ensure that budgets will not be arbitrarily reduced. For example, the budget may not restrict access to other

medically necessary care and services furnished under the plan and approved by the State but not included in the budget. Furthermore, a participant must be informed of how they can request a reassessment if they believe that the budgeted amount is insufficient to meet their needs. Finally, participants may request a fair hearing if the participant's request for a budget adjustment is denied or the amount of the budget is reduced.

25. **Have any of the States using 1915(j) tailored the SPA to serve people with autism or ASD specifically? Same question for States using either 1915(i) or (j) to target people with brain injuries? How can we get a hold of the State Staff that developed these SPAs?**

    Florida's section 1915(j) SPA targeted persons with traumatic brain and spinal cord injuries, among others. The contact information for Florida's SPA is Pam Kyllonep and she can be reached at kyllonep@ahca.myflorida.com.

    As 1915(i) of the Act does not authorize waiver of comparability requirements, States may not limit enrollee access to 1915(i) services for any reason other than assessed need, including limits based on type of disability or other targeting, or limiting the number of persons receiving particular services.

26. **When a State Medicaid agency applies for 1915(i) and 1915(j), I'm assuming the State agency has to amend its original State plan. What process does that require? Is it through the State legislature? Statewide vote? Or varies from State to State?**

    States vary in whether they must have legislation or other authority before submitting a State plan amendment application to CMS. Once it is submitted, however, the CMS process is the same. The SPA must be submitted by the State Medicaid agency electronically to the CMS Regional Office "SPA mailbox", along with the signed and dated HCFA (CMS) form 179 This signifies that it is a formal submission that would start the first 90-day review period. If we need further information, we would issue a formal "Request for Additional Information" (RAI) that the State would have 90 days to answer. Once the answers to the RAI were formally submitted to the Regional Office SPA mailbox, then a second 90-day review period would start. At the end of this period, CMS would either approve or disapprove the SPA.

27. **What quality measures do you anticipate with 1915(j)? How will you assure that the same old "satisfaction" measures are not used? How will you assure that as Tom Nerney says, "we change how we measure quality and raise expectations for people with disabilities"?**

    As of now, we have not set forth required quality measures under the section

1915(j) State plan option. In the preprint for the section 1915(j), we ask States to describe their quality assurance and improvement plan, including the system performance measures, outcome measures, and satisfaction measures that States will monitor and evaluate. We believe requiring certain measures and indicators at this time may be premature as we currently have an initiative underway to evaluate quality measures and indicators as they apply to all Medicaid programs, including this section 1915(j) State plan option. If we determine that certain quality of care measures and indicators will apply to the section 1915(j) State plan option, we would require States to address them.

**28. Under 1915 (j) can you hire a person who is your legal guardian?**

No. We have determined that representatives should not be paid providers of personal assistance services. While it potentially limits a participant's choice of representative or provider, we think it is important to avoid any potential conflict of interest. We also learned from the experiences of the States participating in the original "Cash & Counseling" demonstration, that it is important to include this limitation in order to avoid the situation of a representative overseeing or making decisions that directly impact them, such as approving their own rate of pay, their own timesheets, and the like.

**IMD Exclusion / 1115 Waivers:**

**29. Are there any waivers (like 1115) remaining that allow, through managed care, an override of the IMD exclusion? I would like to work on a consumers guide to CMS reform.**

See next answer below.

**30. IMD exclusion causes confusion - if it is retained, can't qualify for a c waiver. It goes away, then lots of money for IMDs. Why do 1115's allow payment for IMDs? Massachusetts got approval under their 1115 to offer services in an IMD.**

Generally, the section 1115 practice that allowed payments to an IMD for the excluded "IMD population", (i.e., persons aged 22 to 65) has been phased out. There are really only two ways that Medicaid can reimburse IMDs – when They house the covered age ranges (children under 22 and adults over 65), and through the uncompensated care payment through the Disproportionate Share Hospital (DSH) payment. There is wide variation among States in the definitions of hospitals that qualify for the DSH payments and in the amounts of Medicaid DSH payments that are made to qualifying facilities, but some States do pay some limited funds to mental health institutions out of their DSH payments.

**Preventive Services:**

31. **Why does Medicaid fund traditional/typical services/therapies, but not alternative therapies, i.e., music therapy, hippotherapy, etc."  We are often told that individuals must take what Medicaid State plan offers before using waiver dollars.  Alternative therapies are often more cost efficient than traditional therapies.**

    Under some State plan services and in section 1915(c) waiver programs, we have reimbursed for some alternative therapies.  For example, under a State's optional rehabilitative services benefit, we allow States some flexibility because we acknowledge that in rehabilitative services, especially for persons with mental health needs and substance use disorders, recovery may require a "non-traditional" service to be reimbursed.  We would explore whether the non-traditional service is supported by the State's medical necessity definition and the goals and needs identified in a beneficiary's recovery plan.

    Similarly, in some section 1915(c) waiver programs, we have allowed reimbursement for "expressive" therapies such as music, art and equine therapy.  The State must propose, and CMS must approve, such services, complete with a definition, provider qualifications and average rates (including a description of the rate determination methodology).  While a State may be able to cover such services through a 1915(c) program, the State must still be able to assure the cost neutrality of the waiver.

32. **Why does CMS reimburse mental health treatments such as anti-psychotic electroshock but not non-intrusive alternatives such as gym memberships, massages, acupuncture, and peer support?**

    Federal Medicaid has reimbursed for non-traditional State plan services if they are supported by the State's medical necessity definition and the goals and needs identified in a beneficiary's recovery plan.

    We already allow coverage for peer support services if they meet the requirements we have set out in a State Medicaid Director Letter.  We issued the SMD Letter on 8-15-2007.  The SMD Letter can be found at: www.cms.hhs.gov/SMDL/SMD/list.asp.  The Peer Support SMD Letter is #SMD081507A.

**Assessment:**

33. **Has CMS identified an assessment that captures need and can also be used to set rates?**
    CMS does not prescribe the use of a particular assessment tool.  There are a variety of assessment tools and rate setting tools and mechanisms that can be

used and we allow States the flexibility to choose the ones that work best for them that will also meet Federal requirements.

**Auditing:**

34. **Please look at current audit methods and ask yourself what is actually being measured -- process and documentation, not real life outcomes/happiness. Need to rework monitoring/audit methods to be more in line with self-determination.**

    CMS is currently working toward developing and supporting a person-centered long term care system. This system would alter the focus of audits to include such outcomes as whether the person has access to private personal quarters, the option to furnish and decorate that area, the option to choose with whom they share their personal living space, unscheduled access to food and food preparation facilities, assistance coordinating and arranging for the resident's choice of community pursuits outside the residence, the right to assume risk, the ability to earn income and retain assets, the development and maintenance of meaningful relationships, control over transportation, and meaningful community membership.

**Targeted Case Management Regulations:**

35. **The recent changes to the Targeted Case Management regulations are terrible for advocates working to transition folks back to the community. What will it take for CMS to go back to 180 days TCM?**

36. **Will the final case management rules change the 180 days to 60 day back to 180 days?**

37. **Recent definition of case management changes -- do you anticipate they will be reversed? Are States with waivers (e.g. Michigan) exempt from definition of case management changes?**

    **The following response addresses all three questions above**:

    The Targeted Case Management interim final regulation was published on December 4, 2007, with an effective date of March 3, 2008. During the public comment period that ended on February 4, 2008, CMS received many comments on the regulatory provision limiting Federal payment of transition services to the last 60 consecutive days prior to discharge to the community (or the last 18 days prior to discharge, for institutional stays of less than 180

days). The interim final regulation was subsequently placed on moratorium through April 1, 2009. The statutory language implementing the moratorium instructed CMS to not require any Targeted Case Management policy more restrictive than what was set forth in a January 19, 2001 and a July 25, 2000 State Medicaid Director letter. The July 25, 2000 State Medicaid Director letter puts forth the policy of reimbursing Targeted Case Management services provided during the last 180 consecutive days of a Medicaid eligible person's institutional stay, so States may continue to implement this policy through this period of the moratorium.

With the interim final Targeted Case Management regulation being placed on a moratorium, 1915(c) Home and Community-Based Services waivers may continue to provide case management as a waiver service outside of the requirements of the regulation. States may contact CMS for technical assistance on how to implement case management as a waiver service.

**Miscellaneous**

**38. I read about Medicaid programs online -- yet when I try to get more info at my local office and apply -- they know little or nothing about it. Medicaid Part A?? For working adults with disabilities. Is it a rumor or does it exist?**

Unlike Medicare, which is a wholly Federally-run program, Medicaid is a partnership between the States and the Federal government. Each State Medicaid agency must furnish certain mandatory services to certain mandatory populations, but a State Medicaid agency has discretion about whether to offer additional optional services and to whether to cover additional optional populations. If there is no "tie in" between the local social services agency and Medicaid eligibility determinations (which is performed by the Medicaid agency or an entity delegated the responsibility), then local social services offices may not be knowledgeable about Medicaid eligibility or the various programs, services and populations covered in the State. The best way to find out if you are eligible for Medicaid programs is to contact your State Medical Assistance (Medicaid) office.

**39. What is CMS going to do with the residual $300 million left in MFP?**

Since the 31 States were just awarded these grants and are still in the very early implementation phase of the MFP program, CMS has not yet determined how best to utilize the remaining estimated balance of the appropriation over the next five years. Several options include an additional solicitation to bring on more States, increasing the amount of the grants for States based on their ability to transition more individuals to the community, and/or other strategic initiatives that strive to eliminate barriers to community placement.

**40. Please explain how the money truly follows the person under the Money Follows the Person Initiative. In PA, at workshops on this project we are told that it is misnamed. It appears that it will increase the Federal portion for the Medicaid funds and accomplish little else for the individuals participating.**

The program was designed to help States move away from the inherent Medicaid institutional bias and develop programs through waivers or other mechanisms that would effectively and appropriately place an individual in the care setting that fosters or maintains independence. The MFP program provides the financial incentive to States to move persons from institutional care into the community and provide a level of support that would assure that the person remains in the community. In this sense the money is reallocated away from the institution to provide the person continued care in the community and, thus, following the person into the community from the institution. However, functionally speaking, you are correct that "Money Follows the Person" may not adequately describe the program since the money moves to the community program and not necessarily the person.

**41. Many have lost their homes due to foreclosure and their credit history is now Depressed. What is their hope to revive economically while they are caught up in the poverty cycle of disability recovery?**

CMS has several programs that help people produce and keep private income. These programs include grants to develop work incentive services such as the Medicaid Buy-in program, the use of personal assistance in the workplace, and collaborative approaches to supported employment. We recently commissioned a paper from the Rutgers Center for State Health Policy that outlines several measures that States can develop to assist moving people out of poverty. This paper can be found at http://www.hcbs.org/files/137/6821/advanced.pdf .

However, these documents and strategies are only the beginning. Fully realizing these principles will take the work of all stakeholders in all parts of the long term care system.

**42. Why are so many people with disabilities sitting in prisons rather than in programs to help them? Why don't courts recognize disabilities for what they are?**

Too many people with disabilities, particularly mental illnesses, are incarcerated in prisons and jails. We view this as a failure of our system that spends upwards of $250 billion each year to provide services and supports to help people with disabilities live full lives in the community. We have spent millions of dollars in grant money to States to help create integrated systems that would reduce this occurrence. However, we realize that grants to States, although necessary for changing systems are not enough. We are increasingly aware that many of our

policies that were designed to protect the efficient and economic use of Medicaid funding are also significant barriers to working through this issue. We encourage States not to disenroll people from Medicaid when incarcerated so that they can have immediate access to services and supports when released. One of the things needed at this point is a very strong working relationship at the Federal and State level between the justice system and Medicaid to identify the need for and ensure the timely provision of medical services.

**43. Why does it seem that employers are not willing to hire people with disabilities? (My son (28) has not found a job in 3 years.)**

Section 203 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 directed the Secretary of the Department of Health and Human Services (HHS) to establish a grant program to support State efforts to enhance employment options for people with disabilities. The Centers for Medicare & Medicaid Services (CMS) is the designated HHS agency with administrative responsibility for this grant program. The Medicaid Infrastructure Grant (MIG) program is authorized for 11 years.

The goal of the MIG program is to support people with disabilities in securing and sustaining competitive employment in an integrated setting. The grant program will achieve this goal by providing money to the States to develop and implement the core elements of the TWWIIA so as to successfully modify their health care delivery systems to meet the needs of people with disabilities who want to work. Currently, 40 States including the District of Columbia have a MIG. Many MIGs specifically provide outreach to employers regarding hiring people with disabilities. Please visit http://www.cms.hhs.gov/TWWIIA/01_Overview.asp#TopOfPage
for more information.

**44. Given the recent moratorium action needed to delay Medicaid regulations that would eliminate ability to provide habilitative services what is the future of funding services for person with DD - any hope that Medicaid will continue to be a funding source or will we need to develop other funding sources?**

The proposed rehabilitative services regulation is now under a moratorium which restricts CMS from promulgating any policy that is more restrictive than was in place before the proposed rule was published. The rule proposed to eliminate day treatment programs for people with intellectual disabilities and developmental disabilities that were in place prior to 1989. This would have required 16 States to cover their adult day treatment programs under other authorities such as the section 1915(c) Home and Community-Based waiver services program or the section 1915(i) Home and Community-Based services State plan option.

45. **Please explain how the principle of "most integrated setting" fits with providing Medicaid funding to institutions that have no plans to close.**

    Medicaid has been operating under the statutory authority that allows Medicaid funds to pay for room and board in institutions but not in community settings. This has led to an institutional bias in the program. We have provided millions of dollars in grants to States to help them support people in community based settings rather than institutions. While some States have had some success in this direction, these institutions will likely remain open as long as the institutional bias remains in place. There have been many proposals over the years for home and community based services to be required and institutional stays to be rare and of short duration. This would place institutions in the realm of being indicators of the failure of the community based system rather than the default setting for services. This would require legislative action.

46. **Can home help, food stamps, and Medicaid funds be pooled together? This also goes for updated financial forms. You have 3 people doing something one person could do.**

    CMS is supportive of the concept of “braided” funds, rather than “pooled” funds. Pooling funds would result in a loss of identity for those dollars, and would eliminate an audit trail that is needed by each of the separate Federal programs. Braiding funds allows each funding stream to maintain its identity, and maintains an audit trail, while allowing the funds to be combined in a way that addresses each of the beneficiary’s needs. Using this approach, the food stamp funds, housing and Medicaid funds could come together to form the universe of funds available for the individual to use to meet their needs.

47. **What is the projected amount of revenue that would be saved by the enactment of the DRA of 2005?**

    According to estimates projected by the Bush administration upon signing the legislation on February 8, 2006, the Deficit Reduction Act (DRA) is expected to save the Federal government over 40 billion dollars in its first 5 years. Of these 40 billion dollars, more than six billion is expected to be saved from Medicare spending and nearly 5 billion from Medicaid spending. The DRA hopes to reduce the growth in Medicare spending by requiring wealthier citizens to pay higher premiums for Medicare coverage. In regards to Medicaid, the DRA hopes to restrain spending by reducing overpayment for prescription drugs, by granting governors more flexibility in designing programs that effectively and efficiently meet the needs of their States, and by tightening the loopholes that allowed people

to take advantage of the system by transferring assets to their children in order to qualify for medical assistance

48. **In Virginia we continue to hear the Systems Transformation Grant is driving the development of individual budget options. As someone outside the process, it seems like the State Medicaid Office is really stuck on the "how to's" of implementation -- citing reams of difficulties/obstacles to be overcome. Can you identify a helpful role for advocates to play in facilitating movement?**

    Advocates should work with their respective State Medicaid Agency as well as the project director for the initiatives such as the Systems Transformation Grant to ensure their interests are represented.

49. **What role would CMS play in getting change in Social Security work "dis" incentives such as SSA holding people back (oppression, non-taxpayers and heavy administration costs)?**

    The Social Security Administration (SSA) recently announced improvements to the Ticket to Work Program. These changes were published in the Federal Register on May 20, 2008 and went into effect on July 21, 2008. The new regulations are available at **New Regulations** or **New Regulations** in Word Format.

    The revised regulations incorporate SSA's vision of the future direction of the Ticket to Work Program. SSA issued proposed changes to the Ticket Program in 2005 and 2007 based on lessons learned and issues arising from SSA's experience in implementing the prior rules. Changes to the Ticket to Work Program demonstrate that SSA is listening, learning and responding to both lessons learned and critically important feedback from a variety of stakeholders, including beneficiaries, employers, disability organizations, advocates and service providers. The CMS Medicaid Infrastructure Grant encourages coordination with SSA work incentive programs including Ticket to Work. For more information, visit http://www.socialsecurity.gov/work/newregs.html .

50. **With the price of gasoline going up and up, shouldn't our budgets be increased so we can pay for mileage? Especially for people who live in rural areas that have to travel to get to community activities.**

    We are assuming that the question has to do with how a participant in a self-direction program or State plan option can increase the pay of the provider of their transportation service in order to account for increased gasoline prices. We are also assuming that the participant has the authority over a budget, i.e., the amount of funds available for their needed services and supports. This answer will address some general options, and not any specific Medicaid authority.

In general, participants with budget authority develop a "budget plan" or "spending plan" for how they will purchase their needed services and supports. Participants determine the amount to pay their providers of services and reflect that in their budget plan. If gasoline prices are problematic for the provider of transportation hired by the participant, the participant may choose to increase the rate of pay for that individual to account for the higher gasoline prices. Alternatively, if the State offers the ability to save for a particular item that would increase independence or substitute for human assistance, to the extent that expenditures would be made for that human assistance, then perhaps the participant would want to consider "saving" a portion of the budget for a vehicle to replace the person who provides the transportation.

**51. Can CMS help educate the IRS on Microboards? Also, can CMS send a letter to Medicaid directors that Microboards are okay and can be done under states' current systems?**

We appreciate the questions and will discuss them internally to determine what course of action we may be able to take on Microboards.

## This document is posted at:

**www.centerforself-determination.com**