
Shaping policy • Sharing solutions • Strengthening communities


Greetings from
Our Nation's Capital

# *ANCOR GR Presentation*
# *2018 Alliance Summit*
# *June 20, 2018*


***Presented by Esmé Grant Grewal***
***Vice President, Government Relations***
***egrant@ancor.org***

ANCOR

Service providers support more than one million Americans with intellectual and developmental disabilities through the Medicaid program.

**ANCOR is their voice in Washington.**

## Who does ANCOR represent?

Americans with I/DD include people with Down Syndrome, cerebral palsy and autism.

ANCOR is nonpartisan. We represent a workforce of many thousands of community providers across the country who empower people with disabilities to live with dignity – helping them to avoid costly state-run institutional care.

## ANCOR members matter

Our members provide vital services including residential supports, daily life skills building and employment support.

1. **We work tirelessly to protect the Medicaid safety net for those served by our members and to lead the innovation of new and diverse funding streams.**
2. **We champion the full implementation and funding for the ADA and other federal disability rights statutes and regulations.**
3. **We promote innovative and cost-effective business solutions to help our members use limited Medicaid resources efficiently.**

## Facts & Figures

ANCOR represents

**1,400+**

service providers and **52-** state provider associations.

There are more than

**5 million**

Americans with intellectual and developmental disabilities (I/DD) living in the U.S.

Each year, about

**6,000**

babies are born with Down syndrome.

**1 in 68**

children are now born with Autism.

**45%**

of frontline workers leave the field every year, leading to one of the nation's most pressing workforce crises.

# *Legislative Movement*

- The RAISE Family Caregivers Act PASSED and was signed into law
- Kevin and Avonte's Law PASSED and was signed into law
- MFP bipartisan passage en route…
- ALL harmful Medicaid proposals defeated (!)
- ADA Education and Reform Act halted

Congressional Briefings Hosted/Co-Hosted by ANCOR In Past Year

- Technology Briefing (September 2017) – U.S. Senate
- HCBS Briefing (January 2018) - U.S. Senate
- I/DD and Behavioral Health Briefing (March 2018) – U.S. Senate

JUNE 6
2017

# SAVE MEDICAID
## Hill Day and Rally


34,000 emails
ANCOR
17,000 Tweets
Jammed
Capital Switchboards
2017
A Milestone Year

# *Main GR Issues for ANCOR*

- **Accountability**
  - Office of Inspector General Reports
  - Electronic Visit Verification
  - State Model Legislation
  - Workforce
- **State Flexibility**
  - HCBS Settings Rule
  - Money Follows the Person
  - Technology
- **Managed Care**
  - Business Acumen Grant

# *Accountability: OIG Reports*

- **Overview of OIG January 2018 Report**
  - Background of Audits
  - Key Players and Key Takeaways
  - Data and Findings
  - What's Next?

- **Murphy Legislation**

# Who Conducted the Audit Report?


U.S. Department of Health and Human Services
Office of Inspector General,
Administration for Community Living, and
Office for Civil Rights

**Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight**

***Authority:*** *States must provide certain assurances to CMS to receive approval for HCBS waivers, including that necessary safeguards have been taken to protect the welfare of beneficiaries receiving services. (42 CFR Section 441.302). Note this audit was confined to group homes.*

# Initial State Reports - CT, MA, ME

Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (May 2016 – A-01-14-00002)

Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (July 2016 – A-01-14-00008)

Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities (August 2017 – A-01-16-00001)

* Note that OIG makes some reference to their September 2015 report in New York about High Volume Emergency Visits for ICF/IID residents

# Key Takeaways from January 2018 Report

These audits used 2012-2015 Medicaid data and found that these State agencies failed to ensure that:

- Group homes reported all critical incidents,
- All critical incidents reported by group homes were properly recorded,
- Group homes always reported incidents at the correct severity level,
- All data on critical incidents were collected and reviewed,
- Reasonable suspicions of abuse or neglect were properly reported.

# Key Takeaways from January 2018 Report

**Based on OIG's audit work and work with the interagency group, OIG, ACL, and OCR suggest that CMS:**

- encourage States to implement comprehensive compliance oversight systems for group homes, such as the Model Practices, and regularly report their findings to CMS;
- form a "SWAT" team to address, in a timely manner, systemic problems in State implementation of and compliance with health and safety oversight systems for group homes; and
- take immediate action in response to serious health and safety findings, for group homes using the authority under 42 CFR § 441.304(g).

# Key Takeaways from January 2018 Report


**OIG**

- OIG is continuing in additional states (at least 6)
- They are going to expand to other settings like skilled nursing facilities
- Issuing a report to CMS that consolidates the findings from each state

# OIG Reports and DD Improvement Act

- Currently being developed by Sen. Chris Murphy (D-CT).
- In response to OIG reports showing incidents of death/abuse of individuals with IDD. Reports from NY, CT, MA, and ME have emerged, PA just completed, other states across U.S. are expected.
- May create uniform definition of “critical incident” that must be reported
- May create federal law for who is a “mandatory reporter” of critical incidents
- May include a mandatory online training curriculum on abuse and neglect

# *History of EVV Legislation*

## ***Electronic Visit Verification (EVV)***

- Initiated by 21st Century Cures Act passed Dec 2016
- ANCOR Workgroup weighed into CMS in 2017
- ANCOR Memo released to all ANCOR members in April 2018
- Imposes penalty in the form of FMAP reduction for states that do not implement EVV by certain dates
- Personal Care Services: .25% in 2019 → 1% after 2023
- Home Health Services: .25% in 2023 → 1% after 2027
- CMS guidance was due to states January 2018, was published in May 2018
  - Legislative intent suggests I/DD services and non home-based services should be exempt
  - ANCOR is working with Congress and CMS to prevent unintended consequences

# *History of EVV Legislation*

- Derived from November 2015 Republican Medicaid Taskforce
- "Pay for" Legislation in 21st Century Cures Act
- Affects all home health and personal care services for which a provider makes an "in home" visit
- States shall consult with provider agencies, be minimally burdensome, and take in account a **stakeholder process**
- Must document
  - (i) the type of service performed;
  - (ii) the individual receiving the service;
  - (iii) the date of the service;
  - (iv) the location of service delivery;
  - (v) the individual providing the service; and
  - (vi) the time the service begins and ends.
- Per the statute, CMS was to issue best practices on training and notice/education to stakeholders by January 2018

# *ANCOR EVV Workgroup September-December 2017*

- Met with CMS in September 2017, issued input in October and November 2017
- Key Themes of Input
  - Vendor Model (Approved EVV list)
  - Training
  - Payment to Providers and Section 6(a)
  - Concerns of Individuals Served (Privacy, etc.)
  - Adult Foster Care
  - Public Input Process
  - Self-Directed Services and Set Services

# CMS 2018 FAQ: Application

- From the legislation: The term `personal care services' means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a waiver under section 1115
- FAQ Information
  - MCO Services? YES
  - PACE programs? NO
  - ICF/Nursing Facilities? NO
  - Group Homes? NO
  - Other Congregate Residential? NO
  - Everything else? MAYBE
  - Note: Changing title of personal care services…

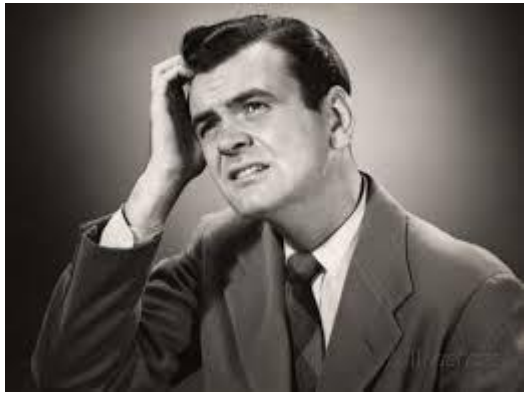
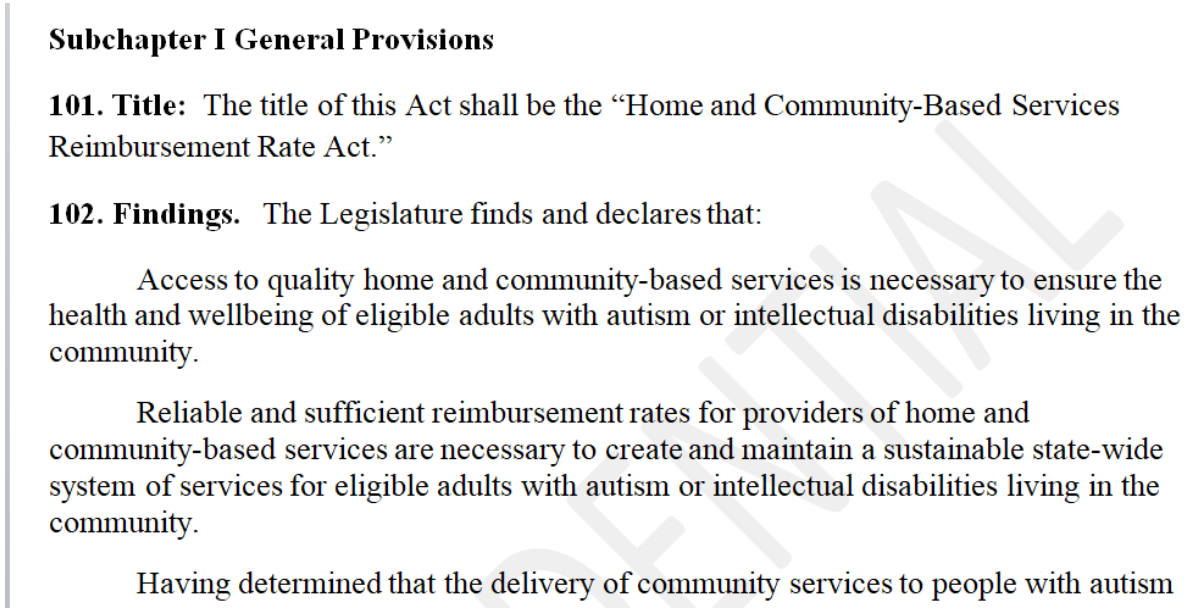


Table 1: Supporting Background, by Model

| Model | Supporting Background |
|---|---|
| **Provider Choice** | A large number of providers currently use one or multiple EVV system(s) that provide a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems. |
| **MCP Choice** | MCPs currently use one or multiple EVV system(s) that provide a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems; the majority or all PCS and HHCS are offered in managed care. |
| **State Mandated In-house System** | Providers are not widely using EVV, or EVV systems being used do not meet the state's needs or the requirements of 1903(l); the state has the expertise and resources to develop its own EVV system, including training and educational materials. |
| **State Mandated External Vendor** | Providers are not widely using EVV, or EVV systems being used do not meet the state's needs or the requirements of 1903(l); the state prefers to use an external EVV vendor for some or all services. |
| **Open Vendor Model** | The state has smaller providers not widely using EVV but may have one or more larger providers using an EVV system that provides a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems. |

# *Accountability: State Model Legislation*

- ANCOR created state model legislation in reaction to lack of federal attention to adequate rates (ex: noninclusion in Access Rule, minimal response to *Armstrong)*
- Developed in 2017/2018 by ANCOR, ANCOR attorneys, and work group of state association members
- Set for release this Spring for use in 2019 legislative sessions – state associations will lead



**Subchapter I General Provisions**

**101. Title:** The title of this Act shall be the "Home and Community-Based Services Reimbursement Rate Act."

**102. Findings.** The Legislature finds and declares that:

Access to quality home and community-based services is necessary to ensure the health and wellbeing of eligible adults with autism or intellectual disabilities living in the community.

Reliable and sufficient reimbursement rates for providers of home and community-based services are necessary to create and maintain a sustainable state-wide system of services for eligible adults with autism or intellectual disabilities living in the community.

Having determined that the delivery of community services to people with autism

# *Accountability: Workforce*

**Our Asks: Support efforts to increase the Direct Support Professionals workforce**

- Sign on to standard occupational classification (SOC) letter to encourage the Bureau of Labor Statistics to designate DSP as a discrete class of workers
- Encourage CMS to confirm Medicaid payments are authorized for the use of innovative technology solutions to deliver HCBS waiver services
- Allow providers to reinvest savings generated by using technology to deliver services
- Annual state reporting of IDD service reimbursement rates
- Revisit the Transition to Independence Act, with a focus on how the DSP workforce enhances community engagement and independent living
- Support federal, state, and local pipeline programs to increase the number of people entering the DSP field

# *State Flexibility: HCBS Settings Rule*

- Compliance of rule now pushed to 2022
- Guidance being reshaped beginning with heightened scrutiny requirements
- NEW guidance expected early this summer

Medicaid.gov
Keeping America Healthy

Search | Archive | Site Map | FAQs

Federal Policy Guidance | Resources for States | Medicaid | CHIP | Basic Health Program | State Overviews | About Us

Home › Medicaid › Home & Community Based Services › Statewide Transition Plans

Statewide Transition Plans
Approval Process

## Statewide Transition Plans

The table below provides all available documents related to Statewide Transition Plans. The table will be updated as states submit additional documents and additional documents are available from CMS. More information about the statewide transition plans and the final HCBS regulation published January 26, 2014, is available under Recent Guidance on the HCBS page.

| State | Status | Documents |
|---|---|---|
| Alabama | Initial Approval | • Alabama Proposed Plan<br>• Alabama Clarifications and/or Modifications required for Initial Approval (CMIA) (PDF 124.63 KB)<br>• Alabama Initial Approval (PDF 177.71 KB) |
| Alaska | Initial Approval | • Alaska Proposed Plan<br>• Alaska CMIA (PDF 81.32 KB)<br>• Alaska Initial Approval (PDF 97.76 KB)<br>• Alaska Initial Approval Addendum (PDF 153.01 KB) |
| Arizona | Initial Approval | • Arizona Proposed Plan<br>• Arizona CMIA (PDF 81.34 KB)<br>• Arizona Initial Approval (PDF 95.37 KB) |

# *State Flexibility: MFP*

House – H. R. 5206 • Rep. Guthrie (R-KY) & Rep. Dingell (D-MI)
Senate – S. 2227 • Sen. Portman (R-OH) & Sen. Cantwell (D-WA)

- **MFP expired in 2016. Where does funding stand in your state?** 9 state MFP programs have already exhausted their funding: Delaware, Illinois, Kansas, Massachusetts, Michigan, New Hampshire, North Dakota, Texas, Virginia 3

- **35 remaining states will exhaust their funding by December 31, 2018:** Alabama, Arkansas, California, Colorado, Connecticut, DC, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, West Virginia, Wisconsin 20

# *State Flexibility: Technology*


- September 2017 ANCOR held Senate briefing hosted by Chairman Hatch of the Senate Finance Committee
- March 2018 10 members from U.S. House of Representatives issued sign-on letter to CMS urging clarity on financing of HCBS technology funding

Congress of the United States
Washington, DC 20515

March 23, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

We write to express our support for the greater incorporation of technology in the delivery of services for people with disabilities under the Home and Community Based Services (HCBS) waiver and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) programs. We encourage the Centers for Medicare and Medicaid Services (CMS) to authorize the innovative use of technology in these important waiver services to: improve service provision; more effectively utilize the skills of direct support professionals given the ongoing workforce crisis; and make more efficient use of Medicaid funding.

Over half of all Medicaid long term care spending is spent on home and community-based services, yet over half a million people with disabilities are on waiting lists for home and community-based services under the 1915(c) waiver alone. We believe that by embracing technological advancements more people can be provided these services under a shared staff model. Examples include remote technology like passive and interactive video support, and unique sensor technology. This would deliver more person-centered and independent services for these individuals while also saving and best utilizing Medicaid funding.

Providers of services for people with disabilities should be able to access federal funding to technological advancements just as other health care systems do, but the current system does not allow for this to occur. For example, standards and requirements for these services should be revisited, including the standard that on-site direct support professional time is the only standard or measure of services that may be delivered, funded, or determine a person's need for support or supervision. We must ensure that regulatory and payment methodologies enable rather than deter service providers and families' access to the most innovative emerging technologies to promote integration and efficiency. These individuals must have the flexibility to transition from on-site staff to technology-enabled remote supervision to increase their functional independence without jeopardizing loss of services or access to adequate resources.

Finally, we encourage CMS to support shared savings models that allow providers to leverage technology-initiated savings to bolster their workforce, to invest in technology for additional

PRINTED ON RECYCLED PAPER

waiver recipients and to serve more people. We believe this is a smart investment in quality services and an effective approach to address long and growing waiting lists for services.

We respectfully request that CMS review and enhance its ability to permit providers of HCBS and ICFs/IID program services to provide services using emerging technology. We also request that CMS communicate to states providers' ability to use emerging technology within their Medicaid partnerships with the federal government.

Sincerely,

Steve Stivers
Member of Congress

Paul Tonko
Member of Congress

Bob Gibbs
Member of Congress

Bill Johnson
Member of Congress

Lee Zeldin
Member of Congress

Barbara Comstock
Member of Congress

Donald M. Payne, Jr.
Member of Congress

Michael R. Turner
Member of Congress

Todd Rokita
Member of Congress

Sheila Jackson Lee
Member of Congress

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAY 17 2018

The Honorable Steve Stivers
U.S. House of Representatives
Washington, DC 20515

Dear Representative Stivers:

Thank you for your letter supporting greater incorporation of technology in the delivery of services to people with disabilities under home and community-based service (HCBS) programs and in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). We agree that technology can play an important role in services for individuals with disabilities.

The Centers for Medicare & Medicaid Services (CMS) permits states to include electronic monitoring devices as "medical assistance" under their state Medicaid plans under section 1915(c) of the Social Security Act (1915(c) HCBS waivers) under the general category of assistive technology and/or environmental modification services. Ohio, Indiana, Maryland, West Virginia and Pennsylvania are several of the states where such services have been approved. CMS reviews a state's proposal to use this technology as it would for other HCBS services under section 1915(c) of the Social Security Act (the Act). CMS may consider other emerging technologies as long as states provide adequate assurances in accordance with statutory requirements, such as they are cost effective, necessary to avoid institutional placement, and provided in a way that assures protection of the health and welfare of the individual.

With regard to the institutional option for individuals in these 1915(c) HCBS programs, if ICF-IIDs choose to supplement resident supervision with electronic monitoring, they must ensure that the monitoring is implemented in a manner that promotes health and safety. It also is important to avoid conflict with regulatory provisions designed to promote personal privacy and awareness of rights.

We recognize the need to deliver services in new and innovative ways based on the evolving availability of technology and the realities of the direct service worker shortages. Together with you and our state partners, CMS will strive for the right balance between innovation and accountability in the provision of needed services to Medicaid beneficiaries including the use of payment models such as shared savings where appropriate.

Thank you for sharing your thoughts. We look forward to continued conversations on ways to more effectively provide Medicaid services. In addition, CMS encourages providers who are interested in utilizing specific technologies to have discussions with their State Medicaid Agency on ways to move forward. If you would like to discuss this further, please contact our Office of Legislation at 202-690-8220. I also will provide this response to the co-signers of your letter.

Sincerely,

Seema Verma

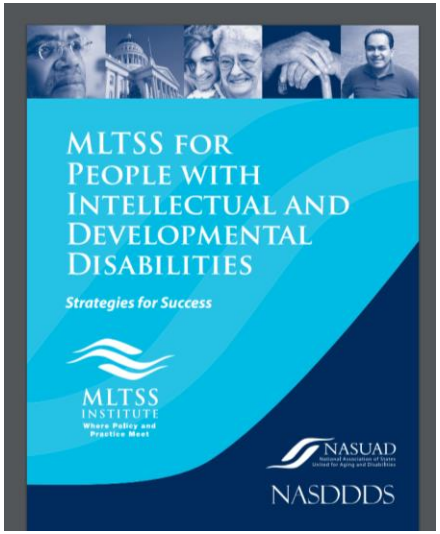
# *Managed Care*

## MLTSS: ANCOR Action

- Engagement in HCBS Business Acumen Resource Center
  - Launching Second Learning Collaborative
  - On-Going Monthly Webinars
    - April – Independent Practice Associations
    - June – Using Data to Drive Action
    - Planning – MLTSS: a CBO Perspective
  - Building a Business Acumen Toolkit
  - Developing White Paper – "The Essential Role of Community Based Organizations in Integrated Care"

HCBS BUSINESS ACUMEN CENTER


Chapter 3 reflects on Medicaid's role as the nation's largest payer for LTSS and the growing trend to deliver these services through managed care. While states typically adopt managed LTSS (MLTSS) after gaining experience with managed care for acute care, the complex needs of people who receive LTSS and the wide range of services they use make implementation of MLTSS more complex. The Commission observes that adoption of new quality measures and efforts to improve encounter data have potential to improve evaluation and oversight activities.



# *Questions?*