

**SUMMARY OF
“A CONVERSATION WITH BARBARA EDWARDS, CMS”
March 23, 2010**

INTRODUCTORY REMARKS

Barbara Edwards spoke about CMS looking for ways to broaden the view of person-centered care, e.g., integration of physical and behavioral health. She described health care reform as “transformational,” saying that Medicaid is about to look very different. CMS does not yet fully understand how changes based on health care reform will impact populations. She urged people to recognize chronic illness as a focus for LTSS and the development of community integration options. She particularly asked to hear about federal policies that create either supports or barriers to serving those in need. She identified a number of cross-HHS, agenda-setting topics: HIV/AIDS, Community Living, Autism, and Mental Health, among others.

- Q. CONDITIONS OF PARTICIPATION: Will CMS allow flexibility or exemptions in the Conditions of Participation (CoPs) for Medicare Certified Home Health Agencies so that these agencies can participate in Medicaid consumer directed care programs?

Background: Recently Ohio created the consumer-directed LTC waiver service of home care attendant service under the Ohio Home Care Waiver Program. In order to participate as a backup when needed for this service, Medicare Certified home health agencies (through ODH) sought CMS approval to waive certain regulations required under the CoPs, especially concerning services directed by the consumer. The “short answer” received was that a Medicare Certified Agency providing these services would be acting outside of the CoPs and found in violation, which puts its Certification in jeopardy.

Barbara Edwards described the CoP issue as one to which CMS staff would be open to discussing in greater detail to make sure the interpretation is correct before trying to answer. She added that at CMS some policies cannot move until CMS is able to ensure that other larger policies do not become a roadblock to them.

- Q. DUAL ELIGIBLES: What are the strategies CMS is considering for integration of Medicare and Medicaid for dual eligibles?

Barbara Edwards described integration of Medicare and Medicaid for dual eligibles as a huge priority of Secretary Sebelius. CMS is looking to see if there is existing authority that might be helpful. Some states are looking at SNPs (special needs plans), though they are not really an integrated product. Many states are working toward a truly integrated funding stream. The new federal Coordinated Health Care Office will be looking at this.

- Q. IMD EXEMPTION: To prevent states from refinancing their state mental hospitals, federal Medicaid policy has excluded payment for services in institutions for mental disease (IMDs) for adults ages 22 to 64 since the 1960s. IMDs are no longer the primary means of care for mental illness, and this exclusion has hampered the development of a comprehensive system of care (through Medicaid waivers) for this population. If this exemption were lifted we could provide more effective and cost-efficient care to individuals afflicted with severe mental illness.

Barbara Edwards response was that this is a complicated issue since it relates both to law and to regulations. She reversed the issue by asking people to think about what they are trying to do, rather than what is the impediment.

- Q. UNIFORM LTC ASSESSMENT TOOL: Because of the relationship between the federal government and states in the Medicaid program, changes at the federal level can influence state operations. As

electronic health records move forward and more individuals will move between HCBS services, NFs, and hospitals, do you see CMS developing a uniform assessment tool for all long-term care or health care settings in the future?

Barbara Edwards reports that CMS is supportive of this concept and sees it as a model for a better balanced system. CMS is working with a contractor on this. She cited ADRC as a unified portal for access to services, suggesting the value of integrating health insurance information with an existing portal rather than providing multiple access points.

- Q. MARKETING OF PACE: Why are nursing homes and the PACE program permitted to do marketing and promotional activities, while such expenditures and activities are prohibited in PASSPORT? PASSPORT is the lowest cost program and given the growing nature of the Medicaid budget, this seems like poor public policy.

Barbara Edwards said there was no PACE approach at this point, but that CMS is “a few steps away.” The challenge is the “friction of components.”

- Q. INDIVIDUAL PROVIDERS: Ohio continues to explore consumer directed options and expand the workforce pool; to that end individual providers are currently available in some of the waivers and are being considered as an option for other waivers. In Ohio that has led to a partnership with a union. How are other states handling payment of union dues/fair share; rate setting; training; oversight and fraud control?
- Q. ELECTRONIC SIGNATURES: New technology has opened many doors for automating completion and submission of applications and forms on line. The guidance currently provided by CMS restricts the use of electronic signatures for the applicant but also for other supporting professionals such as a doctor. Specifically Ohio is very interested in allowing the use of an electronic signature for doctors as it relates to the PASRR process.

Barbara Edwards stated that the system needs to move to support LTSS, adding that the Disabled and Elderly Health Group (DEHG) is focused on this, perhaps even more than its CMS counterparts.

- Q. CARE COORDINATION: The concepts of integration and care coordination being addressed by the Unified Long-term Care Systems Workgroup subcommittee are not new. Does CMS have information on models that other states and communities have implemented and recommendations on which models might be better suited to Ohio?

Barbara Edwards commented on integrating funding streams that it would not be feasible for integrating Older Americans Act funding and Medicaid, but perhaps reporting requirements, e.g., common definition of ADLs (as suggested by Marc Molea). She invited more comments on misalignments or missed opportunities.

In response to a question on the demonstration authority of Secretary Sebilius, Barbara Edwards responded that some are earmarked and that one of the biggest challenges to create a supportive system is the limitation of Medicare and/or Medicaid.

- Q. CARE COORDINATION: Can CMS identify good examples and programs that support care coordination between the dual eligible populations?

Barbara Edwards referenced the recently published guide of tools to implement care coordination in primary care and cited innovative states: Massachusetts, New York (working to maximize Medicare benefit for duals), Wisconsin and New Mexico (using SNPs).

Q. How can we ensure younger people with mental illness can be treated in parity?

Barbara Edwards admitted that this may be a funding issue and suggested that some states should be asking for waivers. She added that in cases where state dollars support IMDs as institutions, they may be able to move that money for other support. On behalf of CMS she acknowledged Ohio's efforts regarding PASRR.

Q. CMS needs to provide better definitions on home-like environments.

Barbara Edwards stated that it is on CMS' list to issue an NPRM by year's end. (They had issued an ANPRM.) There have been problems with getting consensus on this issue. At the "association of associations" meeting (included NASUA, NASADAD, DD, TBI, NASMHPD and others), conversations on this topic are continuing, as well as conversations with cross-disciplinary advocacy groups to identify what is "community." CMS is being cautious in trying to transfer that concept to regulations.

FINAL COMMENTS

She reminded those present that although there are no additional resources for health reform, it is now law, and many health reform provisions relate to aging and disability. In fact, the Olmstead question may create a difference focus.

Barbara Edwards says that CMS staff feels strongly that institutional capacity be maintained as a choice and we need to determine how to make it a better choice.

She underscored states' obligations under ADA and Olmstead and talked about CMS' renewed interest and commitment with the Department of Justice and Office of Civil Rights.

The Disability and Elderly Health Group at CMS wants to provide TA but there is greater emphasis at this time on the compliance side. There is fear that in severe budget times states may regress e.g., try to use Medicare dollars to fill funding gaps for states.

In response to a question about how healthcare reform affects MFP, Barbara Edwards responded that is obviously extended through healthcare reform (unspent dollars). Regarding the 6 month requirement, the bill now talks about 90 days, but the question remains of whether that includes counting Medicare days.

CMS will be issuing new Targeted Case Management regulations.

Barbara Edwards is attuned to opportunities for infrastructure development, noting that states that may be good at diversion may not have the infrastructure in place to do good transitioning.

Barbara Edwards asked people to share their best ideas and information to allow CMS to see potential barriers. She suggested utilizing associations as a conduit for information and recommended ensuring that whatever information is shared is put into context to make it more easily understood.