THE DISABILITY COALITION

A Coalition of Persons with Disabilities, Family Members, and Advocates

Medicaid Redesign – Recommendations

September 8, 2011

General recommendations:

1) Be sure the re-designed system has incentives that favor community placement over facility-based care.

2) Promote consumer direction in all long-term service programs, to improve consumer quality of life and reduce state expenditures.

3) Work with representatives of the disability community on a meaningful and ongoing basis as plans for Medicaid redesign are developed and implemented.

Developmental Disabilities waiver:

4) The DD waiver should not be included in a global §1115 waiver. The Department of Health has engaged in a lengthy process of working with stakeholders to redesign this waiver, and the new waiver just went into effect on July 1. DOH is in the process of refining the new provisions and is continuing to involve stakeholders in that ongoing process. That process should be respected rather than disrupted.

Long-term services and supports (LTSS):

5) Reduce the "silos" that limit access to various LTSS programs: once someone is eligible for Medicaid and meets nursing home level-of-care criteria, allow them to receive the services they need in the appropriate setting without losing eligibility.

- Example: a person with income at 175% FPL who goes into a nursing home or a D&E waiver slot but who needs only attendant services to live successfully in the community could exit the facility or waiver slot and receive PCO services instead, thereby freeing up a waiver slot for someone who needs the broader array of services offered in the waiver.
- If the state is paying managed care organizations (MCOs) to manage care for individuals needing long-term services and supports (LTSS), they should provide the flexibility for the MCOs to do so. In a system where the MCO is paid a capitated rate, the state should not limit access to services based on fear of cost.

6) Implement Community First Choice and use it to replace PCO, serving more people with the same amount of money and reducing the disparity in income eligibility levels among programs.

- Until CFC is implemented, preserve the integrity of the PCO program and maintain a sufficient level of services to meet the needs of program participants.

7) Avoid placing excessive reliance on natural supports to substitute for paid services; rely on them only when they are readily available from a willing source.

- People with disabilities (whatever their age) want to be able to live independent lives in their communities, not to be dependent on family members who have their own lives to lead.

- Families (and friends) are already providing most of the long-term care in this country, as well as paying for a significant percentage of paid supports. They incur financial, emotional and physical burdens to do so. The state should be working to find ways to relieve this burden and position New Mexico to address a growing population of seniors and people with disabilities.
- Forcing family members to provide care regardless of their ability or willingness to do so leads to abuse and neglect.

8) Withdraw the current policy that makes D&E waiver slots available only to persons leaving nursing facilities, which has created a perverse incentive to go into a nursing home in order to get a slot in the community and which allows those individuals to leapfrog over everyone on the waiting list.
- Use Money Follows the Person (MFP) for as many community transitions as possible (creating new waiver slots rather than using existing ones) and allocate vacancies in the waiver to people on the waiting list.

9) Implement MFP as intended. Full and effective implementation of MFP in New Mexico will require:
- A robust program for identifying nursing home residents who want community placement,
- Adequate transition assistance, including the use of trained relocation specialists,
- Accessible, affordable housing and an expanded personal care workforce,
- Strong consumer input into design, implementation, and program evaluation, and
- Including transitions from ICF/MRs.

10) Adopt a plan for expeditiously moving people off the D&E waiver waiting list as required by *Olmstead*. Recommend to DOH that they do the same for the DD waiver.

11) Return the Mi Via self-directed waiver to a less medical and more person-centered model by:
- providing more flexibility in selecting supports to meet individual needs, and
- restoring consumer decision-making authority.

12) Ensure that each Medicaid recipient with a significant disability or chronic health care condition has access to case management/care coordination services.

13) Adopt a streamlined process for annual level-of-care redeterminations for people with permanent disabilities whose condition is not likely to improve. (Federal law requires annual re-assessment but the state should explore use of a simplified process for this population.)

14) If any of the current 1915(c) waivers are included in a global 1115 waiver, ensure that the ability to receive federal matching funds to serve more people through additional appropriations is not jeopardized.

Health care:

15) Promote use of health homes for persons with chronic disease and/or other chronic health conditions.

16) Provide case management/care coordination for those who would benefit from that support.

17) In offering incentives for healthy lifestyles and appropriate use of health care services, be aware of the limits on the ability of people with disabilities to assume “personal responsibility” for their health and care, and don't inadvertently penalize people with

disabilities in any incentive program. People aren't always responsible for their health status or in a position to change it.

18) Co-pays are particularly problematic for people with disabilities who have to use services on a regular and frequent basis. If used:

a) there should be none for services used on a frequent basis by people with disabilities or chronic health needs.

b) they should be imposed in a carefully tailored manner that provides incentives for good use of services and disincentives for inappropriate use, and does not penalize those whose health status requires frequent use of services or who don't have readily available alternatives.

c) they should not be tied to the cost of care. Some of the items and services used by people with disabilities are quite expensive but they are in no way frivolous expenditures.

19) Work with physicians and other providers to educate them and ensure that they have the knowledge, equipment and general ability to provide quality care to people with disabilities.

20) Make sure that any pay for performance measures do not penalize providers for caring for high-needs patients, or create incentives to avoid this population.