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National Association of State Directors of Developmental Disabilities Services

SMD Letter Addresses PPACA Changes to MFP

The Centers for Medicare and Medicaid Services (CMS) has released a State Medicaid Director letter (SMD letter) regarding provisions of the health care reform law that extend the Money Follows the Person Rebalancing (MFP) Demonstration Program for an additional 5 years beyond the original end date of 2011. The letter provides background about the MFP Demonstration Program, explains changes made by the Patient Protection and Affordable Care Act (PPACA), details how the Affordable Care Act will impact current MFP grantees, and provides preliminary information for non-participating states that may be interested in pursuing new funding. According to the letter, the extension of the MFP Demonstration Program through 2016 "offers states substantial resources and additional program flexibilities to remove barriers and improve people's access to community supports and independent living arrangements."

CMS details the changes Section 2403 of PPACA makes to section 6071 of the Deficit Reduction Act (DRA), which authorized the MFP demonstration Program. PPACA extends the MFP Demonstration Program through September 30, 2016, and appropriates an additional $450 million for each fiscal year 2012-2016, totaling an additional

(*SMD Letter* continued on page 2)

Legislative Activity Throughout June Fails to Yield Enhanced FMAP

Despite efforts by Democratic leadership throughout June, the Senate was unable to pass a Tax Extenders Bill with a provision to extend the enhanced Federal Medical Assistance Percentage (FMAP) originally authorized by the American Recovery and Reinvestment Act (ARRA), and scheduled to expire in December of 2010. In May, the House passed its own version of the Tax Extenders bill, but removed the enhanced FMAP provision mere hours before passage in order to gain votes from deficit hawk Blue Dog Democrats.

Medicaid Funds Restored to 'Extenders' Bill Early in June. Senate Finance Committee Chair

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$2.25 billion. Any remaining MFP appropriation at the end of each fiscal year carries over to subsequent years and is available to make grant awards to current and new grantees until FY 2016. Any unused portion of a state grant award made in 2016 would be available to the state until 2020, according to the letter. PPACA also expands the definition of who may be eligible for the demonstration. Under the DRA, only those individuals who had resided in a qualified institution for more than six months were eligible to participate in the MFP Demonstration Program, but under the Affordable Care Act, individuals that reside in an institution for more than ninety consecutive days are now eligible to participate in the demonstration.

According to CMS, "the current MFP Demonstration Programs will experience a seamless transition into the next 5 years of the Demonstration authorized under the Affordable Care Act." CMS will not require currently participating states to compete again through a new solicitation process; they will only need to submit a written request to the CMS Grants Office in the summer of 2011 for continued participation in the MFP grant program. All current MFP grantees may continue to operate their programs within their approved Operational Protocols, but CMS expects and encourages current grantees to explore immediately opportunities to modify, extend, and expand their existing programs in light of the PPACA changes to the program.

CMS also states its intention to post a grant solicitation in late July to www.grants.gov to offer states not currently participating the opportunity to apply for an MFP Demonstration Program Grant through a competitive award process. Early in the solicitation process, CMS will provide states with specifications for developing the grant application, and Assistance to interested states will be provided via state/applicant calls and webinar briefings. If awarded a grant, the state's application will become the Operational Protocol for program implementation, enabling the state to begin transitioning individuals soon after the award. After the posting to www.grants.gov, states will have 120 days to develop and submit the MFP application.

FMI: The SMD letter is available at www.cms.gov/smdl/downloads/SMD10012.pdf.

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(*FMAP* continued from page 1)

Max Baucus (D-MT) offered a substitute amendment to the “tax extenders" bill (HR 4213) that sought to restore the extension of the enhanced FMAP that the House had removed from the bill immediately before passing it. The Baucus language, like that the House had removed, would extend the enhanced FMAP to June 2011, and cost about $24 billion.

The restoration of the Medicaid funding, together with other changes to the bill, would have raised the bill's cost to about $140.2 billion, and the Congressional Budget Office (CBO) estimated that the Senate bill as configured at that point would raise the federal deficit by about $77.5.

Reid Files for Closure on Enhanced FMAP Extension Bill. Senate Majority Leader Harry Reid (D-NV) then filed a motion to stop debate on the bill. The move suggested Reid believed he was close to having enough votes for passage. The Senate would vote on the Baucus amendment first, then vote on the motion to end debate, with a vote on final passage tentatively scheduled for the end of that week.

The move came after Reid rejected a Republican alternative to the bill that would have extended the enhanced Federal Medical Assistance Percentage (FMAP), among other provisions, for just thirty days. Reid and other top Democrats had been working behind the scenes to overcome concerns about the cost of the bill and rally enough support to pass the measure, which would have sent it back to the House for another vote.

Baucus Offers New Substitute Amendment with FMAP Extension After First One Fails. However, the Senate voted 45-52 to reject a Democratic motion to waive a budgetary point of order against the Baucus amendment. As a result, the bill before the Senate at this point did not include any extension of enhanced FMAP provision. However, Democrats then offered a further-scaled-back version of the Baucus Amendment with the hope of securing more support.

The new substitute bill contained the full six-month extension of the enhanced FMAP provision originally authorized by ARRA, and rolled back other, unrelated provisions in order to reduce the overall cost of the bill, which had been the main objection of opposing Senators, who had voted against the bill because of concerns about deficit spending. The new bill also contained new language providing that states would only receive enhanced FMAP between January 1st and June 30th of 2011 if, “not later than 45 days after the date of enactment of [the bill], the chief executive officer of the state certifies that the state will request and use such additional Federal funds.” In other words, governors would need to “opt in” in order for their states to receive the additional Medicaid funding. Senate Democrats said that the changes to other provisions would have made the legislation's final cost about $118 billion and slightly more than 50% of the cost would be offset. Any changes to the House-approved bill in the Senate would have to be approved again in the lower chamber.

Policy Advocates Push for Extension of Enhanced FMAP. Three organizations with a history of advocating on federal issues regarding health care and economic policy continued throughout June to call for increased federal funding for state Medicaid programs.

The Center on Budget and Policy Priorities (CBPP) released a set of talking points regarding the importance of extending the enhanced FMAP for an additional six months. The CBPP materials indicated that, as of April 29, 2010, thirty states assumed the six-month extension of the ARRA FMAP in their budgets, and without it, these states would be “forced to reopen their budgets and adopt even deeper budget cuts and/or tax increases that will undermine the national recovery.” If the FMAP

(*FMAP* continued on page 4)

(*FMAP* continued from page 3)

assistance ends on December 31, 2010, CBPP warned, these budget-balancing measures "will jeopardize numerous private and public sector jobs." CBPP also pointed out that the Congressional Budget Office (CBO) has described temporary FMAP assistance as one of the most effective measures to create jobs and increase demand in the economy, and therefore advised it should be provided without a funding off-set.

The American Federation of State, County, and Municipal Employees (AFSCME) also released a fact sheet calling on the Senate to restore the six-month extension of state Medicaid fiscal relief to the Tax Extenders bill. AFSCME asserted that "helping states with rising demand for Medicaid services at a time of historic revenue lows helps states maintain needed spending for the economy." The union argued that "one of the most important drags on growth comes from the painful fiscal situation in the states," pointing out that the economy would have grown at 3.7% in the first quarter instead of 3.2% – a $70 billion difference – if not for cuts in state and local government spending. Without further federal aid, according to the fact sheet, states would have to close budget gaps with "brutal cuts" that "could cost the economy 900,000 jobs in the near term and more than three million by 2012." AFSCME quoted Mark Zandi, Chief Economist of Moody's Economy.com, as warning that the deep state budget cuts in FY 2011 "will be a serious drag on the economy at just the wrong time," and as saying that every dollar of federal Medicaid relief results in $1.41 in increased economic activity, which translates into stronger economic growth."

Health advocacy group FamiliesUSA sent a letter urging Senate and House leadership to change the Tax Extenders bill to include the FMAP extension. The letter indicated that FamiliesUSA was "deeply dissatisfied" with HR 4213. The letter predicted that without extended FMAP enhancement, "state policymakers will be forced to make devastating Medicaid cuts, including cuts to benefit packages and provider payment rates, and increases in cost sharing."

Bill Fails Again in Senate by the End of June. However, Senate Majority Leader Harry Reid (D-NV) withdrew the tax extenders bill after another failed cloture vote meant the measure failed to pass the Senate for a third time. By this time, the $24 billion extension of FMAP enhancement had been scaled back to $16 billion. States still would have received the aid through June 2011, but the extra FMAP would have gradually reduced from 3.2% in the first three months of 2011 to 1.2% from April to June.

Reid blamed Republican intransigence for killing the measure, while Senate Minority Leader Mitch McConnell (R-KY) argued that Democrats were insisting on legislation that would add to the national debt. It is currently unclear whether individual parts of the "Tax Extenders" package, including the extension of FMAP enhancement, will be taken up separately. Both the House and the Senate have, in different vehicles, passed provisions extending the full ARRA enhancement formula for six months, from January to June of 2011, and opposition to the tax extenders bill has focused entirely on the overall cost of the bill, and not on any objection in principle to the extension of enhanced Medicaid funding.

FMI: To read the bill or see major floor actions regarding it, go to http://thomas.loc.gov and search for bill number HR 4213. The new Baucus substitute bill, and a summary of changes from the first substitute bill (none of which impact the FMAP provisions) are available on the Finance Committee website at http://finance.senate.gov/legislation/details/?id=1c237e70-5056-a032-52e9-ef5f959b7a76. The relevant documents are dated 06/16/10. The CBPP talking points are available at http://www.familiesusa.org/assets/docs/6-2-10-cbpp-fmap-extenders-tps.docx. The AFSCME fact sheet is online at http://www.familiesusa.org/assets/docs/6-3-10-afscme-fmap-fact-sheet.doc. The FamiliesUSA letter can be found at http://www.familiesusa.org/assets/docs/6-1-10-h-r-4213-tax-extenders-bill.doc.

HELP Committee Holds Hearing on Olmstead

The US Senate Committee on Health, Education, Labor and Pensions (HELP) held a hearing this week titled "The ADA and Olmstead Enforcement: Ensuring Community Opportunities for Individuals with Disabilities." Speakers included Cindy Mann, Director, Center for Medicaid and State Operations (CMSO), U.S. Department of Health and Human Services (HHS); Thomas Perez, Assistant Attorney General, Civil Rights Division, U.S. Department of Justice (DOJ); Robert Bernstein, Executive Director, Bazelon Center for Mental Health Law; Kelly Buckland, Executive Director, National Council on Independent Living (NCIL), Jeffrey Knight, former nursing home resident from Frederick, Maryland, and Nancy Thaler, Executive Director, National Association of State Directors of Developmental Disabilities Services (NASDDDS).

NASDDDS Executive Director Nancy Thaler

The hearing was convened by Senator Tom Harkin (D-IA), chair of the committee. In his opening remarks, Senator Harkin described the Olmstead decision as "a critical step forward for our nation, articulating one of the most fundamental rights for all Americans with disabilities – having the choice to live independently." Harkin emphasized Money Follows the Person and the Community First Choice Option as opportunities for states to increase Olmstead compliance.

Thaler, representing state developmental disabilities agencies, outlined the progress state DD systems have made rebalancing their systems over the past thirty years, while also exploring some of the challenges states still face in moving more individuals out of institutions. She told the committee that in 1967, 228,500 individuals resided in large state intellectual/developmental disability (I/DD) institutions and 33,850 in psychiatric institutions, while the most recent national data from 2008 indicates that there were 36,508 in state I/DD institutions – a drop of 194,650 people (84%) since 1967; and 767 in psychiatric institutions, a drop of 33,083 people (98%). Between 1967 and the mid-1980s, she said, 5,000 to 10,000 people moved back into the community each year. Thaler identified key barriers to deinstitutionalization, such as lack of availability of state funding for community services, opposition from institutional employees, and the families of institutional residents, and the institutional bias in Medicaid embodied in the need to "opt out" of institutional services on order to receive community placement.

FMI: Video of the hearing, as well as the written testimony of each of the witnesses, is available at http://help.senate.gov/hearings/hearing/?id=42d620c5-5056-9502-5d70-377b00e43f05. A PDF of Thaler's testimony is available at http://www.nasddds.org/pdf/ThalerSenateCommitteeTestimony(6-22-2010).pdf.

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CRS Examines CLASS Act Provisions in PPACA

The Congressional Research Service (CRS) has produced a paper examining details of the Community Living Assistance Services and Supports (CLASS) program established by the Patient Protection and Affordable Care Act (PPACA) PPACA creates a new Title XXXII of the Public Health Service Act (PHSA) containing a publicly administered voluntary Long Term Care (LTC) insurance program.

This report also discusses the cost and financing for LTC services as well as the current market for private LTC insurance. It discusses the federal budget implications of the CLASS program, as estimated by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS). Finally, the report provides a timeline of CLASS program provisions enacted under PPACA.

FMI: The report is available at http://www.hcbs.org/files/189/9420/CLASS.pdf.

Brief Examines Impact of Health Reform on Medicaid Buy-In

Health and Disability Advocates (H&D) has released a brief examining the likely impact of the health care reform law on Medicaid Buy-In Programs. H&D explores the new law's provisions affecting Medicaid eligibility for people with disabilities, and discusses the "potential new Medicaid enrollment dynamics" that need to be considered as health care reform is implemented.

The brief details the new Medicaid eligibility rules, making note of excepted populations and other quirks in the provisions passed in the Patient Protection and Affordable Care Act (PPACA). H&D points out that eligibility for the newly eligible Medicaid group will be determined based on "modified adjusted gross income," or MAGI. For Medicaid applicants to whom MAGI applies, there will be a five percent income disregard, and states will not be able to apply other income disregards to these Medicaid groups. However, because there is a specific exception to MAGI for people who are eligible for Medicaid based on disability, the MAGI methodology will not limit states' ability to apply additional income disregards to individuals eligible for the Medicaid Buy-In.

FMI: The brief is available at http://www.hdadvocates.org/_files/Health%20Care%20Reform/PPACAAndMBIsHDABriefMay2010.pdf.

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NCCBHC on PPACA and Dual Eligibles

The National Council for Community Behavioral Health Care (NCCBHC) has released a "Fact Sheet on Improving Coordination of Benefits & Care for Dual Eligibles" providing an overview of changes in the Patient Protection and Affordable Care Act (PPACA) to Medicare Special Needs Plans, Medicare Part D cost-sharing, extension of Medicaid waivers, and the newly created Office on Coordination of Benefits.

FMI: The fact sheet is available at http://www.thenationalcouncil.org/galleries/policy-file/Dual%20Eligible%20Provisions%20of%20HC%20Reform%20Bill.pdf.

ROBIN SEZ...

by
Robin Cooper
NASDDDS
Director of Technical Assistance

An intermittent column about Medicaid and Home and Community-Based Services topics and issues of interest to states.

Organized Health Care Delivery System

Over the past few months a number of questions have repeatedly surfaced regarding the use of an Organized Health Care Delivery System (OHCDS). The OHCDS is an option that permits an entity other than the State Medicaid Agency to execute provider agreements and make payments to performing providers. Medicaid regulations under §1902(a)(27) and §1902(a)(32) of the Social Security Act relate to provider agreements and payment. The regulations under §1902(a)(27) require that the provider agreement be with, "every person or institution providing services," meaning every service provider must have a valid provider agreement (and provider number) to bill the Medicaid program. Regulations at §1902(a)(32) require that "no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service." This is referred to as the "anti-factoring" regulation and generally requires that payment be made directly from the Medicaid agency to the provider of services.

These two regulations presented some issues in states that use sub-state or contracted entities to oversee and manage their services systems, like the California Regional Centers or other states' Community Boards. These entities typically provide at least one direct Medicaid service (often case management) and also oversee the planning, delivery of, and payment for other Medicaid services under the Home and Community-Based Services (HCBS) waiver (and/or sometimes the state plan). The regulations regarding the provider agreements and direct payment requirements made it difficult to maintain these long-standing structures. Additionally states may wish to pay "non-typical" providers such as community colleges or purchase bus passes from organizations that are challenged by the usual requirement to enter into a Medicaid provider agreement and bill Medicaid directly.

In a 1993 State Medicaid Director (SMD) letter, the Centers for Medicare and Medicaid Services (CMS) provided states with an alternative called an Organized Health Care Delivery System that permits states to continue the practice of using sub-state or contracted entities to manage the service system and make payments to providers, including "non-traditional" providers. As defined in

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the letter, an OHCDS must be an entity that delivers at least one Medicaid service using their own staff. The OHCDS can execute provider agreements and can make payment to other providers who voluntarily waive their right of direct payment by the State Medicaid Agency and agree to accept payment from the OHCDS entity. Detailed information is available about this option in a December 20, 1993 letter which can be found in Appendix C, State Medicaid Director Letters in the "**Resource Attachments**, Application for a §1915(c) Home and Community-Based Waiver [Version 3.5],Instructions, Technical Guide and Review Criteria," Release Date: November 2007. Also the, "Application for a §1915(c) Home and Community-Based Waiver [Version 3.5], Instructions, Technical Guide and Review Criteria", Release Date: January, 2008, has extensive guidance on the OHCDS option in **Appendix I, Item I-3-g-ii: Organized Health Care Delivery System**, pages 260-262.

In brief, the OHCDS:

1. Must deliver at least one Medicaid service directly using their own staff;
2. Cannot "compel" any providers to affiliate with the OHCDS. They must voluntarily agree to affiliate;
3. Holds the Medicaid provider agreement;
4. Cannot limit who affiliates with them – all qualified providers may do so;
5. Is contractually responsible for the performance of the affiliated providers; and,
6. Cannot compel individuals to receive services through the OHCDS – individuals may receive services from any qualified provider (unless an approved managed care approach limiting freedom of choice of provider is in use).

As noted earlier a couple of questions have come up repeatedly in the past few months, so it is worth reiterating CMS guidance – and of course state DD agencies should always check with their Regional Office if they have specific questions.

Provider Agreements with Subcontractors to the OHCDS

Questions have arisen regarding the requirement for a Medicaid provider agreement as Medicaid regulations at §1902(a)(27) of the Social Security Act , detailed in 42 CFR §431.107(b), require that every provider of a Medicaid service have a provider agreement. But this provision does not apply to providers under the OHCDS option. According to the guidance issued in the 1993 letter, "because [the OHCDS] is the system itself which acts as a Medicaid provider, it is not necessary for each subcontractor of an organized health care delivery system to sign a provider agreement with the Medicaid agency. The [OHCDS] system must have such an agreement and is responsible for ensuring that services it furnishes are provided in accordance with Medicaid law and regulations – including the minimum educational/professional standards for service provision." (Page 6, Provider/Payment Under Medicaid Home and Community-Based Services Waivers and State Plan Services, SMD letter, 12/20/93.)

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OHCDS Administrative Costs

Questions have arisen about how to fund the administrative costs of the entity acting as an OHCDS. States have asked if the OHCDS can "withhold" some of the payment received from the state for the subcontracted providers as a means to cover the OHCDS administrative costs. As an example, the payment for a service for a performing provider is $120/day and the OHCDS negotiates a payment of $100 with the performing provider, using the remaining $20 to cover administrative costs.

Based on the Technical Guide (page 261) this arrangement does not comply with Medicaid regulations. The Technical Guide is quite clear, stating, "When an OHCDS arrangement is employed, it may not be structured in a fashion that has the effect of claiming administrative expenses as service expenses." Thus, the arrangement described above does not comport with the regulations. The OHCDS cannot retain a portion of the service payment to cover their administrative costs. Administrative costs must be segregated and paid at the administrative Federal Financial Participation (FFP) rate, not the service rate.

State DD agencies may want to review the guidance offered by CMS in the Technical Guide and State Medicaid Director letter to assure their OHCDS structure and payment methods are in concert with the applicable regulations and policy.

KCMU Releases HCBS Data Update

The Kaiser Commission on Medicaid and the Uninsured (KCMU) has released a report summarizing the main trends to emerge from the latest expenditures and participant data (from 2006) for the three main Medicaid Home and Community-Based Service (HCBS) programs: optional 1915 (the letter "c") HCBS waivers; the mandatory home health benefit; and the optional state plan personal care services benefit. It also presents findings from the Commission's 2008 survey of HCBS policies such as eligibility criteria, provider, service and waiting list data, and provider reimbursement rates for the home health benefit and the personal care services benefit.

The report indicates that the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007.

Other key findings include:

- In 2006, overall spending on Medicaid HCBS increased 8 percent.
- There was a one percent increase in total participants in Medicaid HCBS programs with nearly 2.9 million individuals being served through these programs in 2006.
- In 2008, all states reported using cost controls on HCBS waivers such as restrictive financial and functional eligibility standards, enrollment limits, and waiting lists.

FMI: The report is available at http://www.kff.org/medicaid/upload/7720-03.pdf.

IACC Seeking Comments on Autism Research Strategic Plan

The National Institutes for Mental Health (NIMH), as part of the Interagency Autism Coordinating Committee (IACC), is seeking public comments to inform the annual update of the IACC Strategic Plan for Autism Spectrum Disorder (ASD) Research as required by the Combating Autism Act of 2006. The law requires that the IACC develop a strategic plan for autism research and update the Plan annually. The first IACC Strategic Plan for ASD Research was issued in 2009 and the first update of the Plan was issued in 2010.

The 2010 IACC Strategic Plan chapters are organized around seven questions that are important for people with ASD and their families:

1. When should I be concerned? (Diagnosis)
2. How can I understand what is happening? (Biology of ASD)
3. What caused this to happen and can this be prevented? (Risk Factors)
4. Which treatments and interventions will help? (Treatments and Interventions)
5. Where can I turn for services? (Services)
6. What does the future hold, especially for adults? (Lifespan Issues)
7. What other infrastructure and surveillance needs must be met? (Surveillance and Infrastructure)

For each chapter of the IACC Strategic Plan, NIMH is requesting "input on what has been learned about the issues covered in that chapter in the past year," and on "the remaining gaps in the subject area covered by that chapter." All comments must be submitted electronically via the web-based form at http://www.acclaroresearch.com/oarc/2010rfi/ and will be accepted through July 30, 2010.

FMI: The request for public comment can be found at http://grants.nih.gov/grants/guide/notice-files/NOT-MH-10-025.html and includes a link to the Strategic Plan.

PHI Fact Sheets Address Looming Workforce Shortage

The Paraprofessional Healthcare Institute (PHI) has released two fact sheets addressing the demographic challenges that will affect the size of the direct care workforce. The first presents occupational employment projections for the three job titles that make up the direct-care workforce: nursing assistants, home health aides, and personal and home care aides, and suggests that over the next decade, the nation's direct-care workforce will constitute the largest, fastest-growing group of jobs in the country. The second provides a detailed overview of the demographic and economic characteristics of the direct-care workforce. Taken together, the two fact sheets provide a detailed look at the demographic underpinnings of the looming direct care workforce crisis.

FMI: The fact sheets are available at http://directcareclearinghouse.org/download/PHI%20FactSheet1Update_singles%20(2).pdf and http://www.directcareclearinghouse.org/download/PHI%20FactSheet3_singles.pdf.

REFLECTIONS ON FEDERAL POLICY

REFLECTIONS ON FEDERAL POLICY

The Ticket to Improving Integrated Employment Outcomes in Your State

In enacting the Americans with Disabilities Act (ADA) 20 years ago, the Congress declared that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." Nearly a decade later, it enacted the Ticket to Work and Work Incentives Improvement Act to provide individuals with disabilities, their families, States, businesses and others the additional tools, opportunities, and supports to achieve these vital aims.

Thanks to rising expectations and corresponding advancements in policy, technology and the nature of the 21st Century workplace, it is now increasingly possible for Americans with developmental and other significant disabilities to become meaningfully employed and self-sufficient. In several States that have adopted a jobs first approach, 40 percent or more of persons receiving supports during the day from their State DD agencies engaged in integrated employment. Yet, in most of the nation, the percentage of such individuals working in integrated employment is only half as much. Moreover, according to the Institute for Community Inclusion, the vast majority of persons with intellectual and developmental disabilities who are employed work only part time, for low wages, make scant use of SSA and other work incentives and, therefore, seldom if ever leave the rolls to become fully self-sufficient as a result.

As explained further in the companion piece, the Ticket to Work Program offers State DD system with a flexible funding stream that especially when used in conjunction with Medicaid can help to incentivize and seed system change that will enable more individuals to become employed, economically independent and financially secured. We are eager to explore with you how the Ticket program can best be used to leverage both reforms and improved employment and self-sufficiency outcomes for workers with intellectual and developmental disabilities in your State.

Dan O'Brien, Acting Associate Commissioner
Social Security Administration's Office of Employment Support Programs

Ticket to Work: A Braided Funding Option

When the Social Security Administration (SSA) issued new rules for the Ticket to Work (Ticket) program in 2008, it made the program a much more attractive business proposition for many organizations and

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agencies. The Ticket program offers access to employment supports and services for people with disabilities, ages 18-64, who receive benefits under the Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) programs. Organizations and/or agencies that are approved by SSA to provide those services (called Employment Networks, or ENs) are paid on an outcome basis, as opposed to a fee-for-service system. Under the original Ticket program rules, some ENs found it difficult to bring in enough money to continue their operations. Now, Ticket payments to ENs are higher, received at an earlier point and some are based on earnings consistent with the beneficiary working part time. The total potential value of each beneficiary's Ticket is around $23,000 – no matter how small the monthly benefit check may be.

In spite of these favorable changes in the Ticket rules, many organizations and agencies were still reluctant to participate in the Ticket program because they receive Medicaid reimbursements and were afraid accepting Ticket payments would be considered "double dipping" and could thereby reduce their operating budgets.

The good news is that on January 28, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director Letter (SMD #10-002) clarifying that there is no conflict with the receipt of Medicaid reimbursements and Ticket payments and would not constitute an overpayment of federal dollars for services provided since Ticket payments to ENs are payment for an outcome rather than for a Medicaid service rendered. (See Federal Perspectives, Volume 17, Number 2, February 2010) Further, CMS encourages state agencies and/or providers to participate fully in the Ticket program. (For a copy of the letter, please visit www.cessi.net/ttw/docs/CMS_Letter.pdf.)

SSA is encouraging agencies and organizations to consider Ticket payments as part of a braided funding approach, along with money from Medicaid and the State Vocational Rehabilitation (VR) programs, to help SSDI and SSI beneficiaries with disabilities achieve their employment goals. Using the Ticket payments as the third braid allows those organizations and agencies a flexible way to fill any gaps since SSA imposes no restrictions on how ENs use the Ticket payments they receive. In other words, supports and services that cannot be funded under the other programs can be paid for from Ticket payments. For example, if a beneficiary needs help with something at home that is interfering with going to work, Ticket payments are flexible enough to be used for that purpose. Ticket money can also be used to hire new staff, buy new equipment or enlarge the EN's office. The key to success, however, is to wait until the Ticket funding stream has started before incurring those kinds of expenses, since Ticket payments are only made after beneficiaries attain the required earnings milestones and outcomes.

Under the Ticket's Partnership Plus provisions, collaboration with State VR agencies is encouraged in an effort to improve long-term employment outcomes. Once a State VR agency closes a beneficiary's case with a successful placement, the beneficiary can assign the Ticket to an EN in the community. That EN may have been the same service provider used under contract by the State VR agency. In fact, that would seem like a good arrangement since the beneficiary presumably is already comfortable working with that provider. The beneficiary, however, is in control of the Ticket and can decide where it is assigned. The important and perhaps misunderstood fact is that the Ticket continues to have value after the State VR agency successfully closes the beneficiary's case. Only the Phase 1 Milestone payments ($5,100 in 2010) are not available to an EN in this scenario, meaning more than $17,000 in potential Ticket payments remains possible. It is this potential funding stream that SSA hopes will encourage long-term supports and services to help beneficiaries not only stay at their current employment levels, but advance in hours worked and earnings received and take advantage of career advancement opportunities.

(*Ticket* continued on page 13)

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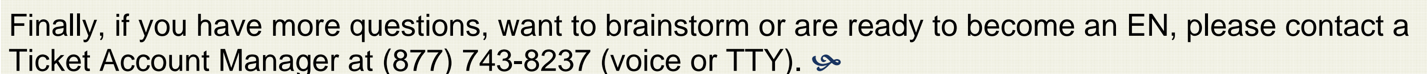
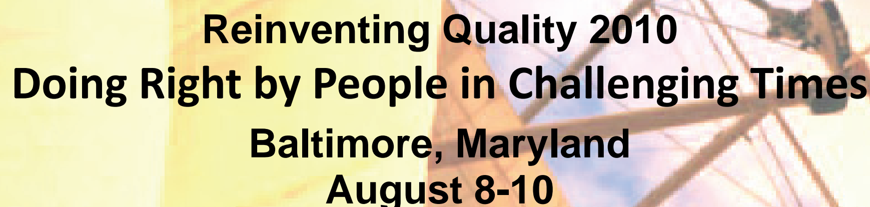
SSA's other Work Incentives wrap around the Ticket to Work and provide the "safety net" for beneficiaries who are interested in trying to work. Again, often misunderstood and underused, the Work Incentives are meant to encourage work while maintaining some or all of the person's cash benefits and health insurance (Medicare and/or Medicaid) for a period of time. That can be a very long period of time depending on a number of factors, including whether the person receives SSDI or SSI. And if the person works long enough and a high enough level to mean no cash benefits are being paid, if he or she stops working within five years of when benefits were terminated, an expedited reinstatement of benefits is possible without filing a new application. SSA may even pay up to six months of temporary benefits while making that reinstatement decision. SSA funds Work Incentives Planning and Assistance (WIPA) projects in every state, the District of Columbia and the US territories to ensure that beneficiaries have the information about how work and earnings impact benefits in order to make an informed decision to try work. These WIPA projects also mean that ENs don't need to be experts in the Work Incentives. Check out www.ssa.gov/work to find more information about the Work Incentives and a directory of WIPA projects.

If you are interested in learning more about the Ticket program, check out www.cessi.net/ttw. The Resources section has many tools and resources including archived Webinars and teleconferences.

If you are thinking of becoming an EN, there are a few things that you can do to help you make that decision. First, review your client records for the past year or so. How many received SSDI and/or SSI? How many of those worked and earned above SSA's "trial work" level ($700/month in 2009 or $720/month in 2010)? How many worked and earned above SSA's "substantial gainful activity" level ($980/month in 2009 or $1,000/month is 2010 for persons with disabilities other than blindness). With this information you can use the EN Revenue Estimator at www.cessi.net/en_estimator to get an idea of how much money you may have received had you already been approved as an EN and taking Tickets from these individuals as well as what is possible for the future. Then talk with your contacts at your State VR Agency. Discuss how the Ticket program is working in your state and how Partnership Plus could help your clients to achieve their employment goals. Think creatively. The Ticket program is so flexible that it lends itself to helping communities overcome barriers to successful employment of people with disabilities.

Finally, if you have more questions, want to brainstorm or are ready to become an EN, please contact a Ticket Account Manager at (877) 743-8237 (voice or TTY).





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