FAMILY VOICES COLORADO

Home and Community Based Children's' Interim Committee

HISTORY

In 2005 with the use of tobacco tax through HB 05-1262, 620 children were taken off waiting lists and placed onto the two existing HCBS Children's Waivers; Children's Extensive Support (CES) waiver, and the Children's Home and Community Based Services (CHCBS) Waiver. This allowed these children access to Medicaid benefits secondary to their insurance family's private, if available.

CURRENT DATA

Today, we have increased the number of HCBS Waivers in Colorado to eligible children. There are now four HCBS waivers for children's. All but one has waiting lists! There are **900+ children waiting** for access to these children's HCBS waivers. Families are told it will be years before their children will be able to access needed healthcare services. *See chart below.* The Children's' Extensive Support Waiver **(CES) has 290 children waiting, Children's HCBS 500** waiting, and **Autism Waiver 200+ waiting.**

	CHILDREN'S HCBS *BIRTH THROUGH 17*	**CHILDREN'S EXTENSIVE SUPPORT** *BIRTH THROUGH 17*	**AUTISM WAIVER** *BIRTH THROUGH 5*	**CHILDREN'S HOSPICE WAIVER** *BIRTH THROUGH AGE 18*
Number waiting	**500***	**290**	**200+***	**0**
Number of current slots	**1,308**	**375**	**75**	**200**
Administered by	**HCPF**	**Health and Human Services-DDD**	**HCPF**	**HCPF**
Designed for children who meet this eligibility	**Medically fragile nursing home level of care**	**Developmentally disabled, line of sight and typically behavior challenges**	**A medical diagnosis of Autism**	**A life limiting diagnosis**

* Numbers must be confirmed by the Departments which administer these programs

Why you might ask, are there so many children with disabilities needing services? Why are the families seeking public health insurance, especially if approximately **80% have private insurance coverage**? The answer is simple, private health insurance coverage is inadequate or lacks benefits for the many high cost services Children with Special Health Care Needs require. Benefits such as: therapies (OT, PT or Speech), durable medical equipment, evaluations, diapers for children over the age of 3, home health care, behavioral healthcare, mental health services, medications, and formula are often excluded benefits or have a very limited package. However, private health insurance is not to blame. There are other factors which need a committee to weight and assess.

The CES, HCBS, Autism and Hospice Waivers were created to address specific needs for children who qualify for a "nursing home level of care". It is cost effective for the State to provide these services and have the child live at home with his/her family.

However, these ***children waiting for services are eligible per Colorado guidelines***. Many of the specific waiver criteria require other eligibility, such as: an additional medical diagnosis, such as Autism, or meeting a Developmental Disability eligibility criteria, according to the State of Colorado. Currently, of the four children's HCBS Waivers, The *Hospice Waiver is the only waiver without a waiting list*. This requires the child to have a "life limiting diagnosis".

Solution

We need an appointed interim committee to focus on both the why of such large waiting lists for our children's HCBS Waivers and to strategize some solutions to resolve the waiting list dilemma. It is my hope to address this problem before the waiting lists get larger or *Colorado is faced with a costly law suit*, such as New Mexico and Texas.

Family Voices believes there are solutions. New Mexico passed a law to provide folks on their waiting list a few hours of respite a month. Through some targeted testimony, we would better understand what families need. Through listening we would be able to develop a streamlined benefit package such as diapers or formula, respite care or a "mini" waiver. Federally, the ***Family Opportunity Act passed in 2007*** giving states the option of creating a **Medicaid buy-in to purchase Medicaid as an insurance**. A similar bill was signed into law under the Owens's administration in Colorado. These are all possibilities to address the Home and Community Based Service Waiver waiting list dilemma.

This interim committee should have a *small scope of only the HCBS children's waivers*, which are administered by both HCPF and HHS, through Division of Developmental Disabilities. Over site by the Single Entry Point (SEP) system and eligibility through both SEP's and Community Centered Boards (CCB's).

PARTICIPANTS

I would recommend the following participants:

- Parents waiting from each of the 3 waivers-3
- Advocacy organizations-2
- Single Entry Point-2
- CCB-1
- DDD-1
- HCPF-the administrators of each waiver-4
- Legislator-2
- Health and Humans Services-1
- Insurance Plan-1
- Provider-2

CONCLUSION

Colorado has been hearing about budget cuts and waiting lists for children and adults with Developmental Disabilities. This solution can be addressed with very real solutions and with motivated people at the table. WE did it with tobacco tax dollars lets do it again!

These are REAL CHILDREN waiting for services
and they Need REAL SOLUTIONS!

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CATALYST CENTER IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

Medicaid Buy-In Programs: Reducing Under-Insurance for Children and Youth with Special Health Care Needs

What is a Medicaid Buy-In Program?

Medicaid Buy-in programs allow individuals or families to purchase Medicaid coverage. This coverage may be the person's only health care coverage or a supplement to private insurance. Buy-in programs make Medicaid benefits available to individuals who would not otherwise be eligible for Medicaid because their income is too high. Some people may pay a premium for this coverage depending on their income and family size. In recent years, many states have implemented Medicaid buy-in programs for adults with disabilities who want to work but fear losing their Medicaid benefits once their income increases above the Medicaid income limits. The recently passed Family Opportunity Act opens the door for states to establish Medicaid buy-in programs for children with disabilities if their family income is less than 300% of the Federal Poverty Level, phasing in the availability of this benefit based on the child's age.

However, several states have operated Medicaid buy-in programs for children with disabilities for many years, offering coverage to families with a wider range of incomes or without phasing in the children by age. Below we describe three of these programs.

How Do Medicaid Buy-In Programs Help Families and Children?

1. Children with disabilities whose families are over-income limits for Medicaid or S-CHIP and who are not insured through their parents' employer may qualify to receive Medicaid coverage. The children do not have to meet an "institutional level of care" test to qualify for Medicaid coverage. This makes it easier for a child to qualify for a buy-in program than it would be to qualify under a state's Home and Community Based Services waiver, Katie Beckett waiver or state plan option.

2. Children who are underinsured because their family's private insurance excludes or places limits on essential services can access Medicaid to cover these services. Examples include medical transportation, durable

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medical equipment and supplies, mental health services, dental care, personal care and prescription drugs. In addition, buy-in programs often cover the private insurance co-payments for services such as prescription drugs, therapies, and mental health services that are often excessive for CYSHCN who have private insurance.

How Do Medicaid Buy-In Programs Help States?

1. States that want to expand coverage for children in general, and for children with special health care needs in particular, can offer Medicaid buy-in programs and receive federal matching funds for the cost of these services.

2. S-CHIP has vastly expanded health insurance coverage for lower middle-income children, but only children who are uninsured can enroll in S-CHIP. It is difficult for states to monitor the extent to which low-income families forgo private family insurance coverage to enroll their children in S-CHIP programs. A buy-in program that sets lower premiums for privately insured children serves as an incentive for families to keep their private coverage. Buy-in programs thus limit the potential for crowd out in which families drop private coverage in order to access public coverage.

How Do Medicaid Buy-In Programs Work?

Three states currently offer Medicaid Buy-in programs for CYSHCN, Pennsylvania (PA), Massachusetts (MA) and Vermont (VT). Technically, the PA program is not a "buy-in," as the state currently does not charge premiums for Medicaid coverage, however the state has a waiver request pending with CMS to implement premiums based on a sliding fee scale for the PA program.

The PA and MA programs both began 18 years ago, in 1988. A change in PA's Medicaid eligibility requirements in 1988 permitted the exclusion of parental income when determining Medicaid eligibility for a child with a disability. The VT program was implemented more recently as an adjunct to the state's S-CHIP program. The PA program is the largest, covering over 32,000 children, while the MA program covers 3,100 children. Both of these programs extend full and partial Medicaid coverage to children who qualify clinically for SSI, but whose families are over income for both Medicaid and S-CHIP.

The VT program is slightly different. Under their 1115 Waiver, *uninsured* children in families with incomes between 225-300% of the Federal Poverty Level may receive state-sponsored health insurance coverage. When the SCHIP program was implemented, there were concerns that families would drop commercial coverage to access the fuller benefit package through SCHIP. This option was offered to allow families to purchase additional coverage under Medicaid. Vermont's Medicaid buy-in program allows *underinsured* children – who would be eligible for S-CHIP if

they were *uninsured*, to purchase Medicaid coverage for services that their private insurance does not cover. The premium payment for this wrap-around coverage is about half the cost of the SCHIP premium. Approximately 1600 children in VT whose family incomes range from 225-300% of the FPL receive partial Medicaid coverage through the buy-in program.

Details on the State Models

Massachusetts CommonHealth Program

- Clinical eligibility: Child must have a disability similar to SSI eligibility criteria.
- Financial eligibility: No income or asset limits. Families over 150% of FPL pay premiums on a sliding fee scale.
- Statutory authority: Originally a state-funded program, now part of a Section 1115 waiver and thus supported by federal as well as state funds.
- Enrollment/Application process: The same application and process is used for CommonHealth as for Medicaid.
- Commonly used benefits for those who buy-in to Medicaid as a supplement to private coverage: Prescription drugs, extended therapies and mental health services.
- Family contributions: Sliding fee scale based on family income and size. See http://www.mass.gov/Eeohhs2/docs/masshealth/eom2003/eom03-04.pdf.
- Other program features: At the family's request, the state may pay their private health insurance premiums.

Pennsylvania Program

- Clinical eligibility: Child must meet SSI disability eligibility criteria.
- Financial eligibility: The countable income of the child (e.g. court-ordered support, disability benefits) can not exceed 100% of the Federal Poverty Income Guidelines (FPIGs). There is no resource test.
- Statutory authority: The Medicaid eligibility requirements for the child are in accordance with an approved State Plan Amendment, using 1902(2) Social Security provisions that allow states to use less restrictive methods to determine eligibility for a specific group of individuals.
- Enrollment/Application process: The same application and enrollment process as is used for Medicaid.
- Commonly used benefits for those who buy-in to Medicaid as a supplement to private coverage: behavioral health rehabilitation services, outpatient and inpatient behavioral health, prescription drugs, speech and occupational therapy and dental care.
- Family contributions: A premium may be charged if the family income is above 200% of the FPIG based on family size, pending federal approval of the waiver.
- Other program features: the majority of children in this program are

enrolled in Medicaid managed care plans.

Vermont Program

- Clinical eligibility: None, any child whose family meets income levels
- Financial eligibility: 225-300% of FPL
- Statutory authority: Section 1115 Waiver
- Enrollment/Application process: The same application and enrollment process is used for Medicaid.
- Commonly used benefits: personal care, dental care, prescription drugs.
- Family contributions: $40 per family per month.
- Other program features: this is only for the purchase of wrap-around coverage, the children have private insurance coverage.

These three programs have had an important impact on families of CYSHCN, helping with private insurance co-payments and deductibles for some families, and providing critical services that private insurance may not cover at all, such as mental health or dental care, for others. This relieves some of the burden on families who have to make choices between going into debt or forgoing recommended care for their child; and is a clear benefit to children who – through the Medicaid program - are more likely to access the full complement of screening services, prescriptions drugs, therapies and other services that their private insurance limits or excludes.

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