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Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law

The Patient Protection and Affordable Care Act signed into law in March 2010 creates a number of new opportunities for states to balance their Medicaid long-term care delivery systems by expanding access to Medicaid home and community-based services (HCBS) programs.¹ The new law contains several provisions that expand Medicaid home and community-based benefit options, broaden financial and functional eligibility criteria, and provide additional financial incentives for states that further shift their Medicaid long-term services budgets to non-institutional settings. Combined, these reforms represent a key opportunity for state Medicaid programs to address the long-term care needs of low-income individuals with chronic and disabling conditions. This brief outlines key provisions in the new health reform law that relate to Medicaid long-term services and supports.

HCBS State Plan Option Expansion

The law provides states with new flexibility under the Medicaid HCBS state plan option that was created in the 2005 Deficit Reduction Act (DRA).² To date, only four states have taken up the option (IA, CO, NV, and WA) that offers HCBS through a Medicaid state plan amendment rather than through a waiver. The new law expands the scope of services covered under the option beyond the eight services that were originally listed under the state plan benefit option.³ Other changes to the option include the removal of states' ability to cap enrollment, the requirement of statewide coverage, the ability to offer the benefit to individuals with a higher level of need, and the ability to target the HCBS option to specific populations (e.g. individuals with specific conditions). The law also creates a new optional eligibility category within Medicaid, and thereby extends full Medicaid benefits, to individuals with incomes up to 150% of poverty who meet the states' HCBS state plan benefit needs-based criteria. Changes to the HCBS option took effect on April 1, 2010.

Money Follows the Person Demonstration Extension

The law extends the Money Follows the Person (MFP) rebalancing demonstration five years through 2016. Authorized by Congress as part of the 2005 DRA, this demonstration program provides states with an enhanced federal medical assistance percentage (FMAP) for twelve months for each Medicaid beneficiary transitioned from an institution to the community during the demonstration period. The goal of MFP is to help states reduce reliance on institutional care for individuals needing long-term services and supports and expand options for individuals with disabilities and the elderly to receive services in the community. Thirty states are currently participating in this demonstration and as of December 2008, roughly 1,400 individuals (or 37 percent of states' targeted transitions) have transitioned back to the community.⁴ The new law requires that eligible participants must reside in an institution for at least 90 consecutive days (the previous residency period was from six months to two years). Days that an individual resides in an institution for the purpose of receiving short-term rehabilitation under Medicare cannot count for the 90 day period required for MFP eligibility. The MFP amendments are effective as of April 22, 2010.

Community First Choice Option

The new law establishes the Community First Choice Option in Medicaid to allow states to provide statewide home and community-based attendant supports and services to individuals with incomes up to 300% of SSI (\$2,022 per month in 2010) who require an institutional level of care through a state plan amendment. The option is designed to give individuals with functional limitations a choice between receiving care in an institutional setting such as a nursing home or in their own homes or community. States that currently extend Medicaid nursing home eligibility to individuals with incomes greater than 150% of poverty may elect to cover higher income individuals with the Community First Choice Option, but only for people with incomes up to the level that would qualify for Medicaid institutional coverage. States taking up the option will receive an enhanced federal matching rate of an additional six percentage points for home and community-based attendant services and supports beginning on October 1, 2011.

The new state plan option is designed to assist individuals with activities of daily living, instrumental activities of daily living, and health related tasks. Services include voluntary training on how to select, manage, and fire direct care workers; and backup services (such as beepers or other electronic devices) to ensure continuity of services and supports. Other covered services include spending for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, other necessities required for an individual to make the transition from an institutional setting to a community setting, and for supports that can increase independence or substitute for human assistance. The new option does *not* cover room and board expenses, assistive technology devices, medical supplies and equipment, home modifications, or vocational rehabilitation.

State Balancing Incentive Program

The law creates the State Balancing Incentive Program that provides enhanced federal matching payments to states in order to increase the proportion of Medicaid long-term services and supports dollars that go toward HCBS. States that spend less than 50 percent of their total Medicaid long-term services and supports spending on HCBS programs are eligible for the enhanced match and can receive the enhanced match on all Medicaid HCBS programs including: HCBS waivers, the mandatory home health benefit, the optional personal care benefit, self-directed personal assistance services and PACE programs.

To qualify for the balancing incentive program, a state must submit an application to the Department of Health and Human Services (HHS) that outlines its plans for expanding Medicaid HCBS and describes its approach to making structural changes in its delivery system. These structural changes include establishing a single entry point system, optional presumptive eligibility, case management services, and the use of a statewide standardized assessment instrument for determining eligibility for HCBS. These changes must be made within six months from the date of application. States are also required to collect data on service utilization, quality measures and on beneficiary outcomes measures.

The law makes available up to \$3 billion in federal matching funds during the balancing incentive period – October 1, 2011 thru September 30, 2015. States that receive the enhanced match must use it to expand or enhance HCBS and may not adopt more restrictive eligibility standards than were in place as of December 31, 2010. The amount of enhanced federal support a state receives will vary based on the percentage of

dollars going towards Medicaid HCBS. States that spent less than 25 percent of their Medicaid long-term services and supports spending on HCBS in FY 2009 will receive a five percent FMAP increase and must target spending at 25 percent of their Medicaid long-term services and supports spending on HCBS by October 1, 2015. All other states that spent less than 50 percent of their Medicaid long-term care dollars on HCBS will receive a two percent FMAP increase and must target 50 percent of spending on HCBS by October 1, 2015. Only five states (OR, NM, WA, AK and CA) currently direct at least 50 percent of their total Medicaid long-term services and supports budgets to community-based services.⁵

Spousal Impoverishment Protections in Medicaid HCBS Settings

The law includes a *temporary* expansion of spousal impoverishment protections to individuals who qualify for Medicaid HCBS. Under current law, Medicaid eligibility rules are more generous for nursing home residents who have a spouse who resides in the community and does not require similar protections for spouses of Medicaid HCBS enrollees. Under current law, states are required to set aside specific amounts of income and assets to maintain a community spouse. The spousal impoverishment protections require states to disregard the income of the community spouse, and a community spouse is allowed to keep half of the couple's joint assets subject to minimum and maximum thresholds. In an effort to reduce Medicaid's institutional bias, the new law requires states to extend spousal impoverishment protections to spouses of individuals being served in Medicaid HCBS programs. This includes spouses of all HCBS waiver participants, including those who qualify as medically needy, as well as those who qualify for the HCBS state plan benefit and the community-based attendant services benefit. This change is scheduled to take effect on January 1, 2014 and will expire on December 31, 2019.

CLASS Program

The law establishes a national, voluntary insurance program for purchasing community living services and supports known as the Community Living Assistance Services and Supports program (CLASS Act). CLASS will work in conjunction with other long-term services and supports programs such as Medicaid. CLASS is designed to expand options for people who become functionally disabled and require long-term services and supports. Adults with multiple functional limitations, or cognitive impairments, will be eligible for benefits if they have paid monthly premiums for at least five years and have been employed during three of those five years. Adults who meet eligibility criteria will receive a cash benefit that can be used to purchase non-medical services and supports necessary to maintain community residence; payments for institutional care are also permitted. The amount of the cash benefit is based on the degree of impairment or disability, averaging no less than \$50 per day. CLASS is financed by voluntary premium contributions paid by working adults, either through payroll deductions or direct contributions. If an individual is eligible for both CLASS program benefits and long-term services and supports under Medicaid, CLASS benefits will be used to offset the costs of Medicaid. The effective date of the CLASS program is January 1, 2011. The HHS Secretary is expected to define the CLASS benefit by October 2012 with enrollment to begin subsequently.

Federal Coordinated Health Care Office

The new law creates an office within the Centers for Medicare & Medicaid Services (CMS) to coordinate coverage and services for individuals who are dually eligible for Medicare and Medicaid. Specific responsibilities of the new federal office outlined in the law include: providing states, special needs plans, physicians and other relevant entities with tools to develop programs that align benefits under

Medicare and Medicaid for duals; supporting state efforts to coordinate acute and long-term services and supports for duals; providing support for coordination of contracting and oversight by states and CMS with respect to the integration of Medicare and Medicaid; coordinating with the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission with respect to eligibility and coverage for dual eligibles; monitoring the provision of drug coverage for dual eligibles; and reporting annual total expenditures, health outcomes and access to benefits for all dual eligibles. The law requires the HHS Secretary to submit to Congress an annual report with recommendations for legislation that would improve care coordination and benefits for dual eligibles.

Summary

Over the past three decades, policy makers have responded to consumer preferences for alternatives to institutional care by expanding Medicaid HCBS programs, yet the majority (59%) of Medicaid long-term services spending still goes toward institutional services. Today almost three million people receive Medicaid HCBS and demand for services in the community is on the rise.⁶ The passage of health reform creates a number of new opportunities for states to balance their long-term care delivery systems by expanding access to Medicaid HCBS programs. Given the significant health needs of the low-income population with chronic and disabling conditions, implementation of these key long-term services and supports provisions will be important to monitor so that the Medicaid program is best equipped to meet both the acute and long-term services needs of the population it serves.

¹ <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>

² Jeff Crowley, Medicaid Long-Term Services Reforms in the Deficit Reduction Act, Kaiser Commission on Medicaid and the Uninsured, April 2006, <http://www.kff.org/medicaid/7486.cfm>.

³ Under Section 1915(c) of the Social Security Act, eight services are explicitly included in the HCBS waiver program, and states can choose to include or exclude these services: case management, homemaker services, home health aide services, personal care services, adult day health services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness.

⁴ Noelle Denny-Brown and Debra Lipson, Early Implementation Experiences of State MFP Programs, Mathematica Policy Research Inc., Number 3, November 2009, <http://www.mathematica-mpr.com/publications/PDFs/Health/MFPfieldrpt3.pdf>

⁵ Enid Kassner, et al, A Balancing Act: State Long-Term Care Reform, AARP Public Policy Institute, 2008, http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf. Data from Arizona and Vermont was not included in the report. Additionally, State Medicaid coverage for home health services was not factored into the data.

⁶ Terence Ng et al, Medicaid Home and Community-Based Services Programs: Data Update, Kaiser Commission on Medicaid and the Uninsured, November 2009, <http://www.kff.org/medicaid/upload/7720-03.pdf>

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