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Promoting Community Living: Updates on HCBS & the ACA

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Introduction

The Affordable Care Act (ACA) significantly expands Home and Community-based Services (HCBS) in the Medicaid program. Four HCBS programs—two brand new—promote and fund policies that help beneficiaries access needed services in the community and facilitate appropriate transitions from nursing homes to integrated settings.[1] Two of the programs, Money Follows the Person (MFP) and the Balancing Incentive Program (BIP), specifically focus on "rebalancing" from an over-emphasis on funding institutional care to promoting coverage of HCBS. The other two, the new Community First Choice (CFC) program and the modified § 1915(i) program, allow states to administer HCBS through their Medicaid state plans instead of relying on temporary waiver programs.[2] All four HCBS programs seek to expand access to HCBS services, empower individuals to choose where and how they live, maintain beneficiary protections and shift states to a more person-centered model of care. The ACA reforms also accommodate state flexibility in program design. And since HCBS are typically cheaper than institutional care, states that successfully rebalance should save money. The four optional HCBS programs have different features that impact state participation, which has varied widely in the post-ACA landscape (See Table 1).

Money Follows the Person (MFP)

Established by the Deficit Reduction Act of 2005 and based on earlier state pilot projects, MFP provides enhanced federal financing for states to transition individuals who want to move from a nursing facility to supported community living settings. MFP has two components: a transition program to help identify potential candidates and a

[1] The federal Department of Health & Human Services (HHS) has proposed rules to define integrated settings where HCBS may be offered. Generally, the setting must be incorporated in the broader community and, in the case of provider-controlled settings, demonstrate qualities that distinguish it from institutional care, such as residents' freedom to come and go as they please, set their own schedules, own or rent the units, and have access to private bathrooms.

[2] CFC is found at § 1915(k) of the Social Security Act (SSA), 42 U.S.C. § 1396n(k). We refer to it as CFC to avoid confusion with the § 1915(i) state plan HCBS option. HCBS waiver programs are typically authorized through § 1915(c) (42 U.S.C. § 1396n(c)) or § 1115 (42 U.S.C. § 1315). Waivers are subject to periodic renewals and must not increase federal expenditures relative to baseline projections. For more details on waivers and budget neutrality, see Cynthia Shirk, *The Basics: Medicaid Waivers and Budget Neutrality,* Nat'l Health Policy Forum, 1 (August 26, 2009), http://www.nhpf.org/library/the-basics/Basics_MedicaidBudgetNeut_08-26-09.pdf.

rebalancing program intended to reform long term care systems to better incentivize and facilitate supported community living. States receive up to 90% federal match to cover participants' HCBS as well as some expenses related to moving and setting up a new residence.[3] Individuals can qualify for enhanced match for up to 12 months after leaving institutional care, but states must continue to provide HCBS to those individuals for as long as they remain eligible. Participating states must also maintain or expand their level of HCBS expenditures.[4] By 2007, 30 states and the District of Columbia had received grants for MFP programs.[5]

The ACA extended MFP through 2016 and expanded eligibility by relaxing the minimum institutional residency requirement from 6 months to 90 days (not counting short-term rehabilitation).[6] With the shorter timeframe, individuals are more likely to have access to prior housing and vital social support networks necessary for successful transitions.

Updates

Since 2010, 13 additional states have received MFP grants, with 3 more states applying in 2012.[7] This makes it by far the most widely utilized ACA HCBS program. Generally, states that had existing transition programs, like Texas, have demonstrated success quickest, while other states have taken several years to implement system reforms.[8] Of the programs approved in 2011, Idaho, Massachusetts, Rhode Island and Tennessee reported successful transitions by January 2012.[9] Cumulatively, states had transitioned

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[3] The federal contribution to a state's Medicaid program varies according a formula based on the Federal Medical Assistance Percentage (FMAP). 42 U.S.C. § 1396d(b). A state's FMAP is based on per capita income and varies from 50 to 83%. The MFP "enhanced match" formula is FMAP + 0.5(1-FMAP) and cannot exceed 90% for any state. 42 U.S.C. § 1396a note.

[4] HCBS expenditures include federal and state Medicaid HCBS spending for individuals through HCBS waiver programs and other Medicaid HCBS state plan options such as home health services and personal care services, as well as managed care spending related to HCBS in states with such coverage. This includes HCBS spending on MFP participants, but not administrative costs. Total expenditures must remain above FY 2005 levels or the year prior to the demonstration, whichever is greater. 42 U.S.C. § 1396a note.

[5] Susan C. Reinhard, *Money Follows the Person: Un-burning Bridges and Facilitating a Return to the Community*, 36 J. of the Am. Soc'y on Aging 52, 54 (2012).

[6] 42 U.S.C. § 1396a note.

[7] Two pre-ACA MFP grantees, Oregon and South Carolina, suspended their programs. The thirteen new grantees are: CO, FL, ID, ME, MA, MN, MS, NV, NM, RI, TN, VT, & WV. Alabama, Montana and South Dakota applied in 2012. U.S. Gov't Accountability Office, GAO-12-649, *States' Plans to Pursue New and Revised Options of Home- and Community-based Services*, at 17-21, (2012).

[8] Texas' "Rider 37" program, established in 2002, served as a model for the MFP and gave the state a head start on implementing structural changes. As of June 30, 2011, Texas had transitioned 4,658 individuals from nursing homes into community settings, or 29% of transfers for the entire MFP program. Susan C. Reinhard, *supra* note 5, at 54-55.

[9] Susan R. Williams et al., *Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2011,* Mathematica Policy Research, Reference No. 06352.400, at 23, (June 2012), available at: http://www.mathematica-mpr.com/publications/PDFs/health/mfp_jul-dec2011_progress.pdf.

nearly 20,000 individuals by the end of 2011, a nearly 65% increase over the 2010 total.[10] A study identified three specific policies present in the most successful programs: a standardized process to ensure that MFP transition coordinators and HCBS waiver programs work together; a system to allow flexibility for local transition coordinators to spend more time on individuals with greater needs; and staff housing specialists to aid transition coordinators.[11]

MFP still faces some structural challenges. First, the lack of affordable housing, a familiar issue in HCBS policy-making, poses a significant barrier to successful transitions.[12] A second challenge is who transitions. Nearly two-thirds of the individuals transferred under MFP have been younger people with disabilities or mental illness, yet up to 75% of the potentially eligible candidates are elderly.[13] Some of this is attributable to how states have prioritized different populations and selected local and regional partners. For example, Indiana targeted the elderly and people with physical disabilities, while Iowa's program focuses solely on people with intellectual disabilities.[14] The relative underrepresentation of older adults may also result from statutory language that prohibits participants from transitioning to a facility with more than four unrelated individuals.[15] This disqualifies most assisted living facilities from receiving MFP funds, although many elderly adults appear to prefer such facilities.

Balancing Incentive Program (BIP)

BIP shares the MFP goal of facilitating supported community living for qualifying individuals. This ACA-established program targets states that spend less on HCBS than on institutional long term supports and services (LTSS).[16] Like MFP, BIP offers states

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[10] *Id.* at ix.

[11] Debra Lipson et al., Mathematica Policy Research, *What Determines Progress in State MFP Transition Programs?*, *The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program: Reports from the Field issue #8*, at 1 (2011), http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt8.pdf.

[12] In one evaluation, 22 of 25 responding states cited limited housing resources as a top impediment to successful transitions in their MFP programs. Lipson et al., *supra* note 11, at 4. As more states transition LTSS populations to Medicaid managed care, one strategy is to require managed care entities to take on full risk of nursing home placement to encourage these organizations to develop creative housing solutions and so facilitate more successful transitions.

[13] Debra Lipson et al., Mathematica Policy Research, *Money Follows the Person Demonstration Program: A Profile of Participants*, *The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program: Reports from the Field issue #5*, at 5 (2011), http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt5.pdf.

[14] Susan R. Williams et al., *supra* note 9, at 7.

[15] Debra Lipson et al., *supra* note 13, at 3.

[16] For the purposes of BIP eligibility, institutional care includes LTSS provided in nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID, formerly ICF-MR), Institutions for Mental Disease (IMD), long term care hospitals and psychiatric hospitals that are not IMDs. HCBS (non-institutional LTSS) include care provided through HCBS waivers or SSA § 1929(a), the Program for All-inclusive Care for the Elderly (PACE), home health services, personal care services, self-directed personal assistance

enhanced federal matching rates for instituting LTSS system reforms. Specifically, states must:

- establish a "no wrong door" system for LTSS access;
- provide conflict-free case management services; and
- create a standardized assessment tool to determine HCBS eligibility.

Participating states must meet expenditure targets by September 30, 2015, when the program ends. The ACA established two funding tiers. States spending less than 25% of LTSS expenditures on HCBS get a 5% enhanced federal match rate for non-institutional LTSS services and must raise HCBS expenditures above 25% by 2015.[17] States currently spending 25-50% of LTSS services on HCBS get 2% enhanced match and must meet a 50% expenditure target. All enhanced federal matching payments must fund new or enhanced HCBS.[18]

Updates

The ACA provided $3 billion for this program, but the uptake of BIP began slowly with only Maryland and New Hampshire receiving approval in 2011. By September 2012, six more states (including Mississippi) received BIP funding, with other states showing interest.[19] A GAO report based on interviews with state Medicaid administrators lists common participation barriers, including states' limited capacity to run a new program and the upfront costs of new IT and data-reporting infrastructure for a time-limited program. The need to change state assessment procedures and streamline eligibility may also deter participation, although both would ultimately reduce administrative costs and improve consumer experience.

In addition, uncertainty about the future of ACA implementation and the prioritization of major Medicaid expansion and other mandatory state Medicaid reforms over optional programs has further limited uptake. The final deadline for submitting BIP applications is August 1, 2014, so states still have time to make use of this dedicated funding.[20]

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services and non-institutional LTSS provided through managed care organizations. BIP bases eligibility on FY 2009 data, and initial calculations identified at least 13 states that appear ineligible for BIP (AK, AZ, CA, CO, DC, MN, NM, OR, KS, VT, WA, WI & WY). Centers for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement*, at 18 and Attachment C, (2011), http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Final-BIPP-Application.pdf.

[17] Currently only Mississippi qualifies for the 5% enhanced match.

[18] For more detail on balancing incentive payments, *see* Balancing Incentive Program, *Payments and Funding,* (August 21, 2012), http://www.balancingincentiveprogram.org/taxonomy/term/66.

[19] In addition to NH and MD, CMS has approved BIP programs for: IA, MS, MO, GA, TX, and IN.

[20] Balancing Incentive Program, http://www.balancingincentiveprogram.org/getting-started, (Jul. 24, 2012).

§ 1915(i) HCBS State Plan Option

The Deficit Reduction Act of 2005 also created a new HCBS state plan option, the § 1915(i) program. It offers two significant new HCBS flexibilities. First, unlike other HCBS waiver programs, individuals do not have to meet a nursing facility level of care to be eligible. Second, the state plan option does not have a periodic renewal process as required under a waiver, easing administrative costs and effort for states. Iowa was the first state to take up this option in 2007, followed by four other states.[21]

The ACA changed several provisions of the § 1915(i) option and recent proposed rules include even more flexibility in benefit design and targeting. States now have the option of using § 1915(i) for individuals otherwise eligible through an HCBS waiver program. This raises the income limits for § 1915(i) services to as much as $2,094/month for an individual and potentially allows states to consolidate certain services across various programs under the state plan, which can improve coordination.[22] States now also have flexibility to provide full Medicaid benefits to individuals up to 150% FPL who meet the § 1915(i) medical needs-based criteria and to target specific populations and tailor the specific HCBS offered to each targeted population.[23] For example, Iowa's § 1915(i) program offers case management, supported employment and habilitative services for individuals with functional deficits related to chronic mental illness. The ACA eliminated states' ability to target particular geographic regions or place hard caps on program enrollment, though states can adjust enrollment by changing the needs-based eligibility criteria.[24]

Updates

The changes instituted by the ACA have increased state interest in this option. Idaho, Oregon and Louisiana all implemented § 1915(i) programs in the first half of 2012. In addition, CMS is currently reviewing § 1915(i) applications from four other states.[25] California submitted two state plan amendments that demonstrate the flexibility of this option. One amendment offers habilitative services for individuals with developmental disabilities while the other targets infants and toddlers with developmental delays and provides their families a one day training to prepare for the transition to school.[26] The latter essentially shifts an existing state-funded program into federally-matched

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[21] Nevada (2008), Colorado (2008), Washington (2010, removed 2011) and Wisconsin (2010) were the other early implementers.
[22] The income limit is three times the Social Security Income ($698/month x 3 = $2,094 in 2012).
[23] The proposed rule allows targeting based on age, diagnosis, disability, or Medicaid eligibility group, and permits states to limit the amount, duration and scope of services available to targeted groups. 77 Fed. Reg. 26402, 42 C.F.R. 441.656(e)(2) (proposed).
[24] ACA § 2402(e), codified at 42 U.S.C. 1396n(e) (enrollment caps), and ACA § 2402(f), codified at 42 U.S.C. 1396n(f) (geographic regions). If a state narrows needs-based criteria, it must grandfather in currently eligible beneficiaries.
[25] The four states with applications under review are: CA, CT, FL and NC. U.S. Gov't Accountability Office, *supra* note 7, at 24.
[26] *Id.* at 24.

Medicaid. Given this versatility, § 1915(i) option will likely become an increasingly common feature of state plans.

Community First Choice (CFC) State Plan Option

Established by the ACA, CFC provides states with a 6% enhanced federal match to cover services to assist individuals with Activities of Daily Living (ADLs), habilitative services and back-up systems like electronic emergency indicators. CFC also gives states the option to cover many of the costs of transitioning individuals from institutional care to supported community living, including rent deposits, moving expenses and some nonmedical transportation. Some of these services complement the transition services.

Like the § 1915(i) option, states cannot cap enrollment and must apply coverage statewide, but CFC forbids targeting by age, disability, or type of service needed and requires beneficiaries to meet a nursing facility level of care.[27] Additionally, states have less flexibility in determining covered services than under § 1915(i) or HCBS waivers. Participating states must also implement a number of administrative reforms and consumer protections, including quality assurance systems, training standards, data reporting, a stakeholder feedback process, due process procedures, and program evaluation plans.

Updates

In September 2012, California received CMS approval for the nation's first CFC state plan amendment, which shifts the state's In-Home Supportive Services program to the state plan. CFC's 6% matching increase will boost federal funding by an estimated $573 million over the first two years.[28] Louisiana submitted a state plan amendment in June 2012. Maryland is preparing a CFC state plan amendment to carve out allowable CFC services from three existing programs (two waivers and its state plan HCBS) and consolidate them with the enhanced match. State officials plan to use some of the savings to increase HCBS benefits. Arkansas has also announced plans to shift some attendant care services into a new CFC program.

Broad state participation remains uncertain, although some states may have been waiting for HHS' final rule implementing this program, issued on May 7, 2012. With the enhanced federal match and the opportunity to consolidate HCBS under one streamlined program, CFC offers another win-win for states and beneficiaries. This may offset the greater flexibility of the § 1915(i) program. While § 1915(i) allows states to adjust needs-based criteria, target specific populations, and create a state-specific set

[27] The final rule reversed an earlier proposed rule that did not require an institutional level of care. 42 C.F.R. § 441.510(c).

[28] Press Release, State of California Health and Human Services Agency, California Receives First-in-the-Nation Approval of New Community-Based Care Option for At-Risk Seniors and Persons with Disabilities (Sept 4, 2012), http://www.dss.cahwnet.gov/cdssweb/entres/pdf/PressRelease/CommunityFirstChoice.pdf.

of HCBS benefits, it does not offer an enhanced federal match. States may, of course, elect to do both programs.

Conclusion

Coordinating HCBS

The ACA sought to expand and streamline HCBS in states. While each HCBS option has different features, the programs are meant to overlap and work together. As states begin to plan and implement the options, they are discovering new ways to coordinate and consolidate. For example, Mississippi will use MFP funds for administrative reforms to help satisfy some BIP requirements, such as the standardized needs assessment tool. It has also created a Learning Collaborative, including experts and consumer stakeholders, to analyze and advise on how all the state's rebalancing efforts fit together. Arkansas and Maryland will link CFC state plan amendments with new BIP programs. These early implementers provide useful models for other states to evaluate how best to improve and expand their HCBS options and should help increase participation in the ACA HCBS reforms going forward.

Table 1—Features of Four HCBS Programs

Program	MFP	BIP	1915(i)	CFC
Eligibility	Beneficiaries must be Medicaid eligible and have spent at least 90 days in long-term institutional care.	Any qualified Medicaid HCBS beneficiary in participating states	Beneficiaries must meet medical needs-based criteria, be Medicaid eligible under the state plan, and have income ≤150% FPL.[1]	Beneficiaries must be Medicaid eligible in a category that includes nursing facility services, or have income ≤150% FPL and be eligible in Medicaid category without NF services.
Level of Care Threshold	Institutional	N/A	Less than institutional	Institutional
Enhanced Federal Match	Up to 90% FMAP for some services within 12 months after NF transition	2% or 5% enhanced FMAP for non-institutional LTSS services[2]	None	6% enhanced FMAP for qualified services
Targeting	• Applications must include targeting criteria and participation projections	N/A	• Targeting based on diagnosis, age, disability, or Medicaid eligibility group • Medical needs-based criteria can be service specific • Statewide • No enrollment cap	• Statewide • No enrollment cap
Other Notable Requirements	State must: • maintain or expand HCBS services; and • continue to provide HCBS as long as the participant is still eligible.	State must establish: • "no wrong door" eligibility system • standardized LOC assessment tool • conflict-free case management services	State must: • define conflict of interest standards and ensure that independent agents conduct eligibility evaluations and needs assessments; and • ensure that each individual has a person-centered service plan.	States must: • implement administrative reforms and consumer protections, including quality assurance systems, training standards, data reporting, a stakeholder feedback process, due process procedures, and evaluation plans; and • maintain or expand HCBS for first 12 months.
Services included	• HCBS available to participants under state plan or waiver; • HCBS specific to the MFP program;[3] and • Supplemental services that facilitate transition, such as a security deposit on an apartment or payment of overdue electricity bills[4]	• Most non-institutional LTSS covered under state plan or waivers	Any or all of the following: • case management; • homemaker services; • home health aide services • personal care services; • adult day health services • habilitation services; • respite care services; • special services for individuals with chronic mental illness; or • other services as approved by HHS	All of the following: • assistance with ADLs, IADLs (especially attendant and personal care services); • acquisition, maintenance and enhancement of skills to accomplish ADLs and IADLs; • backup systems to ensure continuity of services and supports; • voluntary training on how to select, manage and dismiss attendants; and • at state option, expenditures for transition costs and other expenditures relating to a need identified in an individual's service plan
Duration	Through 2016	Through 9/30/2015	Ongoing	Ongoing

[1] The proposed 1915(i) rules give states options to provide full scope Medicaid to otherwise ineligible individuals with income ≤150% FPL (no asset test), or with income ≤300% SSI who are eligible for state HCBS waiver. 77 Fed. Reg. 26399, 42 C.F.R. 435.219 (proposed).
[2] Enhanced match payments must fund new or enhanced HCBS.
[3] States may offer MFP-specific Medicaid-allowable HCBS that go beyond the scope or amount of HCBS offered to other Medicaid beneficiaries. Deborah Lipson et al, Mathematica Policy Research, *Money Follows the Person 2010: Annual Evaluation Report*, at 2 (2011), http://www.mathematica-mpr.com/publications/pdfs/health/MFP_2010_annual.pdf.
[4] Supplemental MFP services vary by state, but are not typically covered by Medicaid and are reimbursed at the state's regular FMAP rate. *Id.* at 2.