Short Paper #8

The ACA and Home and Community-Based Care Options
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Background

The Patient Protection and Affordable Care Act ("ACA" or "the Act") was enacted in March 2010.[1] The ACA will dramatically expand access to health insurance, and it also contains provisions designed to improve health through other means. This short paper discusses several provisions designed to make home and community-based services (HCBS) available to more Medicaid beneficiaries.

Expanded State Plan Option to Offer Home and Community-Based Services

The Deficit Reduction Act (DRA) of 2005 added section 1915(i) of the Social Security Act, which authorizes states to provide HCBS through a Medicaid state plan.[2] Previously, such services could be offered only pursuant to 1115 or 1915 waiver programs.[3] Section 1915(i) enables states to serve individuals with incomes under 150 percent of the federal poverty level (FPL) who need supportive HCBS but whose functional limitations are less severe than those served under HCBS waivers. It is intended to provide states with an opportunity to offer services and supports in the home and community before individuals need institutional care.[4]

Participating states must establish criteria for determining an individual's need for covered HCBS that are less stringent that those the state uses to determine eligibility for institutional services.[5] Services covered are those that could be covered for 1915(c) waivers: case management, homemaker/home health aide and personal care, adult day health, habilitation, respite care, and other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.[6] States may also allow individuals to direct their own care.[7] States must use an

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[1] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter ACA].
[2] 42 U.S.C. § 1396n(i), added by the Deficit Reduction Act of 2005, Pub. L. No. 109-362, 120 Stat. 2064 (2006).
[3] 42 U.S.C. § 1315 (authorizing waivers to enable states to run pilot programs to test innovative methods of service delivery) (Section 1115 of the Social Security Act (SSA)); § 1396n(c), (d), (e) (authorizing home and community based waivers to serve individuals who would otherwise need the level of services provided in an institution) (Sections 1915(c), (d), and (e) of the SSA).
[4] *See* Centers for Medicare and Medicaid Services, *Dear State Medicaid Director*, "Improving Access to Home and Community-Based Services," (Aug. 6, 2010) (emphasis added), http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf.
[5] 42 U.S.C. § 1396n(i)(1)(A).
[6] *Id.* §§ 1396n(i)(1), 1396n(c)(4)(B).
[7] *Id.* § 1396n(i)(1)(G)(III).

independent evaluation to determine an individual's eligibility and an independent assessment to determine the necessary level of services and supports in an individualized care plan.[8]

The ACA makes several significant changes to the 1915(i) option. First, it enables states to expand eligibility to individuals with incomes up to 300 percent of the SSI benefit rate (about $2022 per month) and who are eligible for (but not necessarily enrolled in) a 1915(c), (d), (e), or 1115 waiver.[9] It also expands the scope of services that may be covered. One important difference between 1915(c) waivers and the original 1915(i) option was that, under 1915(c) waivers, it was possible for states to cover services not specifically listed in the statute as long as the Centers for Medicare & Medicaid Services (CMS) approved.[10] In contrast, the 1915(i) option as first enacted restricted coverage to those services specifically listed. The ACA removes this limitation and states may now offer other CMS-approved HCBS services under 1915(i).[11]

In addition, the 1915(i) option now allows states to waive Medicaid's comparability requirement, which requires states to cover services in an equal amount, duration, and scope for all beneficiaries who qualify for them.[12] Thus, states can offer HCBS to specific, targeted populations and offer a different amount, duration, and scope of services to different groups. CMS issued a letter in August 2010 explaining how states might do this:

> For example, a State could propose to have one 1915(i) benefit that is targeted and includes specific services for persons with physical and/or developmental disabilities, and another 1915(i) benefit targeted to persons with chronic mental illness. Another State might implement one 1915(i) benefit that is targeted to children with autism and adults with HIV/AIDS, but specify different services to meet the needs for each targeted population group within the same overall benefit package.[13]

States are no longer allowed to waive the requirement that services be available statewide nor to place caps on enrollment and maintain waiting lists.[14] But, they may still limit enrollment indirectly. They are required to project and report to CMS the number of individuals that they expect to receive services under 1915(i). If enrollment exceeds a state's estimate, it may modify the needs-based eligibility criteria to restrict further enrollment without getting advance permission from CMS. The State must give CMS and the public at least 60 days notice of such modification, and any individuals who are eligible for services will remain so until they no longer meet the original eligibility criteria.[15]

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[8] *Id.* § 1396n(i)(1)(E), (F), (G).
[9] *Id.* § 1396n(i)(6).
[10] *Id.*. § 1396n(c)(4)(B) (allowing coverage for "such other services requested by the State as the Secretary may approve).
[11] ACA § 2402(c), amending 42 U.S.C. § 1396n(i)(1).
[12] 42 U.S.C. § 1396a(a)(10)(B).
[13] Centers for Medicare and Medicaid Services, "Improving Access to Home and Community-Based Services."
[14] ACA § 2402(e), (f), amending 42 U.S.C. § 1396n(i)(1)(C), (3).
[15] *Id.* § 1396n(i)(1)(D)(ii)(I).

1915(i) plan options may operate for five years and be renewed for an additional five year term.[16]

The ACA also creates an optional category of eligibility that includes individuals who are eligible for home and community-based services through 1915(i). This would allow states to cover the full scope of Medicaid benefits for qualified individuals, such as physician services, hospital care, and home health, rather than only covering HCBS.[17]

There is good reason to welcome the 1915(i) option as it offers an additional way for states to expand coverage of HCBS. In particular, it improves states' ability to cover services for people with mental illnesses.[18] It is especially helpful that states may no longer have waiting lists for 1915(i) services. But, while this flexibility may encourage states to offer benefits that they otherwise would not, it also defeats part of the purpose of having a benefit offered as part of a state plan, i.e. that states must cover benefits in an equal amount, duration, and scope for all eligible individuals. And, advocates should be aware that states could attempt to use the option to limit services. For example, North Carolina requested permission to offer personal care services (PCS) to individuals living in adult care homes through a 1915(i) plan option. At the same time, it requested permission to limit the scope of PCS for individuals living in their own homes. On balance, this would have allowed the State to reduce coverage of PCS, a crucial community based service, through a tool intended to expand the scope of coverage of HCBS. Advocates understand that CMS may reject this request. But, based on examples given by CMS itself, a state could eliminate coverage of PCS for everyone, then reinstate coverage only for people with physical disabilities, thus circumventing the comparability requirement and resulting in a net loss of HCBS. Thus, the issue requires close monitoring by advocates.

Community First Choice (CFC) Option

Beginning October 1, 2011, states have yet another option to provide HCBS attendant care and support services through a state plan amendment to Medicaid enrollees.[19] Services may be made available to those with incomes up to 150 percent FPL (about $28,000 per year for a family of three), or, at the state's choice, to the state income limit for eligibility for nursing facility services under the state plan if it is greater. In some states, this income limit is as high as 225 percent of FPL.[20]

The CFC Option also has a two-tiered clinical eligibility standard. States may cover individuals with incomes above 150 percent of FPL only for individuals who meet eligibility

[16] 42 U.S.C. § 1396n(j)(B). Renewal is conditioned on the Secretary of the Department of Health & Human Services determining that the state complied with the requirements of the subsection and met quality and outcome improvement goals . *Id.*

[17] *Id.* § 1396a(a)(10)(A)(ii)(XXII).

[18] For further discussion of this topic, *see* Judge David L. Bazelon Center for Mental Health, "Webinar: Adding Support Services to Medicaid: Now You Can," (broadcast Oct. 12, 2010), available at www.bazelon.org.

[19] 42 U.S.C. § 1396n(k) (section 1915(k) of the SSA), added by ACA §2401, as amended by Recon. Act § 1205.

[20] *Id.* States are allowed to cover nursing facility or HCBS services for individuals with incomes up to 300 percent of the SSI level (currently equal to about 225 percent of FPL). *See* 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(V), 1396b(f)(4)(C).

standards for nursing facility services.[21] Individuals with incomes up to 150 percent of FPL may qualify regardless of whether they are nursing facility eligible. This two-tiered clinical eligibility standard is based on CMS's most recent stated interpretations of the statute, but is not yet explicitly stated in any formal CMS guidance.[22]

The CFC Option provides for coverage of services to assist with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks.[23] The statute describes services which are mandatory, optional, and specifically excluded:[24]

Mandatory	• Attendant care services • Acquisition, maintenance, and enhancement of skills necessary to accomplish ADLS, IADLs, and health related tasks • Back up systems and mechanisms to maintain continuity of services, such as beepers or other electronic devices • Voluntary training on how to select, manage, and dismiss attendants
Optional	• Expenditures for transition costs such as rent and utility deposits or first months' rent and utilitied • Bedding, basic kitchen supplies, or other necessities required to transition from an institutional setting • Expenditures that will increase independence or substitute for human assistance that would otherwise be provided
Excluded	• Room and board costs (other than the transition services listed above); • Special education and related services • Assistive technology devices and services other than those specifically listed in the available services • Medical supplies and equipment • Home modifications

States have a significant incentive to adopt this option because the proportion of federal funds they receive for covered services will be increased by 6 percentage points. There is also a "Maintenance of Expenditures" provision requiring any state adopting this option to at least maintain state expenditures for Medicaid services provided to elderly and disabled individuals during the first full fiscal year that the state adopts the option. Because these are state plan, as opposed to waiver, services, spending limits and caps are prohibited, and services must be made available statewide and in comparable amount, duration, and scope among beneficiaries.

States must provide CFC services "in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life."[25] Services may not be provided

[21] 42 U.S.C. § 1396n(k)(1) .
[22] The statutory language creating the two-tiered clinical eligibility requirements, at the newly created §1396n(k)(1), is ambiguously written so as to also allow for a one-tier interpretation that the nursing facility eligible requirement applies to all potential beneficiaries, including those at or below 150percent of FPL.
[23] *See* 42 U.S.C. §1396n(k)(6) for detailed definitions.
[24] 42 U.S.C. § 1396n(k)(1).
[25] 42 U.S.C. §1396n(k)(3)(B).

in nursing facilities, institutions for mental diseases, or other intermediate care facilities for people with mental retardation.

Services must be provided according to a person-centered plan of care and based on an assessment that is agreed to in writing by the patient or their representative.[26] A significant implementation question at the state level will be how these critical specialized assessment protections based on the new provision will be fully adopted in states which are likely to be relying on existing personal care assessment mechanisms.

In addition, the services may be provided through an agency model or other model, such as provision of vouchers, direct cash payments, or use of a fiscal agent.[27] The patient (or her representative) must control the services to a significant degree and have the right to select, manage, and dismiss a provider. Patients must also have access to services provided by qualified family members, as defined by the Secretary.

There are important questions about how the CFC option will be implemented. For example:

- Both CFC and the 1915(i) option are available to individuals under 150 percent of FPL. How will states decide between CFC and 1915(i) expansions? Given the enhanced match for CFC services, and the very small number of states that have until now adopted 1915(i) services, will states be more likely to implement CFC options? Will 1915(i) services be more robust and preferable for individuals?
- Will states be tempted to drop some HCBS services they currently offer to shift towards CFC services to receive a higher federal fund match to the detriment of some enrollees? For example, a state could eliminate personal care service coverage and move the enrollees into CFC, but some individuals in the personal care services may be qualifying at a lower level of acuity than the Community First Choice Option would allow.
- Would a state eliminate a waiver with specialized services not available through the CFC, or otherwise more tightly cap eligibility pursuant to a waiver?

Money Follows the Person

The Money Follows the Person (MFP) program was also authorized by the DRA 2005 and provides for grants to states to help them move individuals from institutional settings into community-based settings.[28] States may receive enhanced matching funds during the first 12 months after an individual leaves the institutional setting. The enhanced matching funds provided by the MFP program have created a strong incentive for states to promote de-institutionalization of populations that could be in community settings, as evidenced by the quick adoption of the program by a significant number of states (currently, 29 states and D.C.) receive grants) and the number of individuals transitioned using these funds. [29]

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[26] 42 U.S.C. §1396n(k)(1)(A).
[27] 42 U.S.C. §1396n(k)(6)(C)(ii).
[28] Deficit Reduction Act of 2005, Pub. L. No. 109-171 §6071, *codified at* § 1396a note.
[29] Noelle Denny-Brown and Debra J. Lipson, *Early Implementation Experiences of State MFP Programs*, Mathematica Policy Research, Inc., Reports From The Field (Nov. 2009) available at: http://www.mathematica-mpr.com/publications/pdfs/Health/mfpfieldrpt3.pdf.

MFP was originally authorized to run until 2011. The ACA extends the MFP program for five years, until 2016.[30] States retain the authority created in the DRA 2005 to request waivers for their MFP programs related to Medicaid requirements on statewideness, comparability, and income and resources eligibility.[31]

The ACA also loosens one key eligibility criteria for the MFP program. Originally, an individual had to be institutionalized for at least 6 months to 2 years prior to transfer to a community-based setting for her community-based services to qualify for MFP funds.[32] The ACA reduces the 6 month to 2 years requirement to 90 days, meaning individuals will be eligible for MFP funds earlier, and thus reducing the institutional timeframe.[33] The reduced timeframe is extremely significant because the longer an individual resides in an institution, the more rapidly their condition may deteriorate and their connections to community-based alternatives decrease.

Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes, ACA § 10202

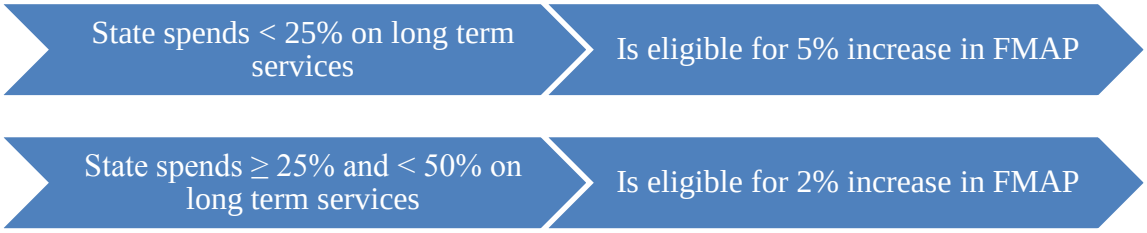
This section creates the State Balancing Incentive Payments Program (SBIPP) to offer states the incentive of an increase of 2 or 5 percent to a State's federal matching rate for covering community-based "long-term care services and supports" (LTCSS).

Statutory Definition of "Long Term Services and Supports"	
Institutionally Based Services	Non-Institutionally Based Services
services provided in an institution, including nursing facility and ICF-MR services	(1) home and community based services provided under a waiver pursuant to 1915(c), (d), or (i) or 1115; (2) home health care services; (3) personal care services; (4) services provided pursuant to Programs of All-inclusive Care for the Elderly (PACE); and (5) self-directed personal assistance services.

The SBIPP is open to any state that currently devotes less than half of its Medicaid long term care expenditures to non-institutional services.[34] In 2007, this described all except six states.[35] To be eligible for participation, a state must submit an application that includes a budget detailing the state's plans to expand and diversify non-institutionally based Medicaid LTCSS in order to achieve the targeted percentage rate.[36] A State may participate in SBIPP either through a state plan amendment or through a federal waiver.[37]

[30] ACA §2403(a).
[31] DRA 2005, §6071(d)(3).
[32] DRA 2005, §6071(b)(2)(A)(i).
[33] ACA §2403(b)(1)(A). Days of residency that are solely for the purpose of receiving short-term rehabilitative services during Medicare's waiting period will not be counted toward the 90 days.
[34] ACA, § 10202(b)(1).
[35] *Id.* § 2406(a)(4).
[36] *Id.* § 10202(c)(1)(B); *see also* § 2402, discussed above.
[37] *Id.* § 10202(f)(4).

The FMAP for which a participating state qualifies is determined based on its proportion of Medicaid expenditures for HCBS. If in fiscal year 2009, the State spent less than 25 percent of its long-term care and support services money on HCBS, the State may receive a 5 percent increase in its federal matching rate for any non-institutionally based LTCSS it provides by adopting a target of increasing the amount spent on HCBS to 25 percent.[38] States that spent more than 25 percent and less than 50 percent may adopt a target of 50 percent and receive a 2 percent increase in the State's FMAP for non-institutionally based LTCSS.[39] A maximum of $3 billion in total aggregate payments will be available under this program.[40]



For all participating states, there is a maintenance of eligibility requirement: the State may not apply standards, methodologies, or procedures for determining eligibility for non-institutionally-based long-term care and support services provided pursuant to the SBIPP that are more restrictive than the eligibility standards, methodologies, or procedures that were in effect as of December 31, 2010.[41] Any additional funding that the state receives under this program must be used to provide new or expanded non-institutionally-based services in the State's Medicaid program.[42]

To be eligible for this program and the additional funding, the State must agree to make certain structural changes within six months of applying for the program.[43] The required structural changes are:

- The State must develop a "**No Wrong Door—Single Entry Point System"** for individuals to access all long-term services and supports.[44]
- Creation of **conflict-free case management services** to develop a service plan.[45]
- Development of **core standardized assessment instruments** to determine eligibility for the non-institutionally-based services and supports and to develop an individual service plan.[46]

[38] *Id.* § 10202(c)(2)(A), (d)(1).
[39] *Id.* § 10202(c)(2)(B), (d)(2).
[40] *Id.* § 10202(e)(2).
[41] *Id.* § 10202(c)(3).
[42] *Id.* § 10202(c)(4).
[43] *Id.* § 10202(c)(5). While an earlier section seems to imply that states have flexibility in choosing which changes to make, this later section clearly requires states to implement six structural changes in order to qualify for the program. *Compare* § 10202(c)(1)(A) *with* (c)(5) and (c)(6).
[44] ACA § 10202(c)(5)(A).
[45] *Id.* § 10202(c)(5)(B).
[46] *Id.* § 10202(c)(5)(C).

Participating states must also agree to (1) c**ollect services data on a per-beneficiary basis** from all providers of non-institutionally-based services and supports; [47] (2) c**ollect core quality data** that are based on population-specific outcome measures and accessible to providers; [48] and (3) **develop outcomes measures** that are population-specific and accessible to providers. The outcomes measures must include beneficiary and family caregiver experience with providers, satisfaction with services, and beneficiary-specific measures which indicate whether desired outcomes are achieved in the individual case.[49]

States that participate in this program may receive the enhanced federal match for expenses for non-institutionally based LTCSS incurred during the "balancing incentive period," which runs from October 1, 2011 through September 30, 2015.[50] States must meet the target percentages of non-institutionally-based services and supports by October 1, 2015.[51] However, the six structural changes must be made within six months of application.[52]

Conclusion

The ACA provides states with many opportunities to increase access to Medicaid services in homes and communities, helping to shift Medicaid away from its traditional institutional bias. Advocates should welcome and promote adoption of these options in their state. Yet, there are potential risks as well, because states may use them in a way that results in fewer individuals having access to HCBS.

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[47] *Id.* § 10202(c)(6)(A).
[48] *Id.* § 10202(c)(6)(B).
[49] *Id.* § 10202(c)(6)(C).
[50] *Id.* § 10202(e), (f)(2).
[51] *Id.* § 10202(c)(2).
[52] *Id.* § 10202(c)(5).