

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS
OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

States have significant roles in implementing practically all aspects of the Affordable Care Act. This *State Health Policy Briefing* focuses on the Act's provisions that give states additional options for financing Medicaid home and community based services and supports (HCBS) through a combination of enhanced Medicaid matching payments, demonstrations, and new Medicaid state plan options. It describes these new provisions and analyzes the scenarios under which states might adopt them. The State Balancing Incentive Payments Program and an amended Money Follows the Person Rebalancing Demonstration are time-limited incentive/grant programs that provide states with enhanced Medicaid matching payments in exchange for state adoption of initiatives designed to increase the proportion of their total long term services and supports (LTSS) expenditures devoted to non-institutional services. Most qualifying states are likely to apply to participate in these programs. The Community First Choice Option and an amended State Plan HCBS option permit states to amend their Medicaid state plans to adopt new permanent optional authorities for financing HCBS. In determining whether to adopt these new options, states will assess whether they improve upon the current Medicaid authorities they now use to finance HCBS, namely Medicaid Section 1915(c) HCBS waivers and state plan personal assistance.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

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Implementing the Affordable Care Act: New Options for Medicaid Home and Community Based Services

BY DIANE JUSTICE

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The Affordable Care Act includes several important policy initiatives aimed at enhancing the availability of long-term services and supports, including a groundbreaking new program called CLASS, a voluntary public insurance program financed by enrollees. Long-term services and supports policy was also advanced through a broad range of provisions addressing the direct care workforce, Aging and Disability Resource Centers, and Medicare Advantage Special Needs Plans. Many of the new Medicare and Medicaid demonstrations designed to improve chronic care will include among their participants persons needing long-term services. And perhaps most relevant to this issue brief, the ACA established the Federal Coordinated Health Care Office, charged with improving care for persons dually eligible for Medicare and Medicaid services.

Four provisions were enacted that are specifically designed to give states additional options for financing Medicaid home and community-based services and supports through a combination of enhanced Medicaid matching payments, demonstrations, and new Medicaid state plan options. All are strategies states can choose to adopt, and each has requirements and opportunities that states will need to assess before determining which ones are both feasible to implement and will advance their policy agendas.

This issue brief describes these new opportunities and analyzes the scenarios under which states might implement them. Since states' long-term services and supports (LTSS) systems vary considerably, so too will the criteria they need to consider. Two of the provisions are time-limited incentive/grant programs aimed at helping states shift the balance of their total Medicaid funding for LTSS to rely more on supports provided in the community rather than in institutions. These include the State Balancing Incentive Payments Program and the amended Money Follows the Person Rebalancing Demonstration. The other two provisions permit states to amend their Medicaid state plans to adopt new permanent authorities for financing home and community based services and supports (HCBS). These include the Community First Choice Option and an amended State Plan HCBS option.

In the near term, the overwhelming fiscal pressures facing states will limit their ability to significantly increase Medicaid financing for HCBS. During this time, the State Balancing Incentive Payments Program and Money Follows the Person provide states with an important opportunity to focus on improving the organization and delivery of HCBS while building their capacity for program expansion when state economies begin to recover. Both programs offer enhanced Medicaid matching payments for HCBS in exchange for state adoption of initiatives designed to increase the proportion of their total LTSS spending devoted to non-institutional services. Since the enhanced match must be used by states to further the availability of HCBS, the provisions both stimulate systems reforms and finance additional services. For most states, the benefits to be gained through their participation in these programs will be obvious.

Community First Choice Option and State Plan HCBS are inherently different than the time-limited grant and demonstration programs in that they establish permanent, optional Medicaid state plan authorities for financing HCBS. They both establish an individual entitlement to Medicaid HCBS, reflecting the long-standing principle held by many that LTSS provided in the setting most preferred by consumers should have equal status with the Medicaid entitlement to institutional services. States will need to consider whether they will adopt them and if so, under what circumstances. The most central questions are: how do the new provisions compliment the other Medicaid authorities states are currently using to finance services and supports? And in current state fiscal environments, are they affordable?

The primary Medicaid authority states currently use to finance home and community based services is the Section 1915(c)

HCBS waiver program, which does not provide an entitlement to services. Instead, it enables states to annually budget for the number of persons who will be enrolled in the program and establish participant wait lists when that level is reached. As a result, in most states, not all people who qualify for program benefits are able to receive them. But through this financing method, states have been willing and able to incrementally invest state funds to build delivery systems that provide community based services and supports to persons who would otherwise require institutional care.

In this current fiscal climate, states are struggling to maintain the levels of support for Medicaid HCBS that they have already achieved, and will not be in a position to consider establishing new broad-based entitlements with the risk they bring for unpredictable expenditures. For now, the two new Medicaid funding authorities may, in large measure, be options that states aspire to adopt in the future. However, as this issue brief suggests, there are some scenarios under which states might consider adopting them in narrowly defined manner.

DEMONSTRATIONS AND GRANT PROGRAMS TO PROMOTE LTSS SYSTEMS BALANCING

STATE BALANCING INCENTIVE PAYMENTS PROGRAM

The State Balancing Incentive Payments Program will provide enhanced federal matching funds to states that adopt strategies to increase the proportion of their total Medicaid LTSS spending devoted to HCBS and implement delivery system reforms that will increase consumer accessibility to needed services and supports. States that devote less than 50 percent of their total Medicaid LTSS expenditures to home and community based services are eligible to compete for up to \$3 billion in enhanced matching payments for their expenditures on Medicaid 1915(c) HCBS waivers, PACE programs, and home health and personal assistance under the Medicaid state plan.

To qualify, a state must submit an application to the Secretary of DHHS, presenting a proposed budget that details the state's plans to expand Medicaid funding for non-institutional services and supports. It must also describe the state's approach to making three major structural changes in its delivery systems which are: 1) establishment of a "No Wrong Door— Single Entry Point System" that creates a statewide system of access points for long term services and supports; 2) adoption of conflict-free case management; and 3) application of core standardized assessment instruments for determining eligibility

for non-institutional services and supports used in a uniform manner throughout the state. All three reforms must be made by states within six months of submitting their applications.

States must also collect data on service utilization, core quality measures, and consumer outcome measures. States chosen by CMS to participate in the program may not adopt more restrictive standards and methodologies for determining eligibility for Medicaid home and community based services and supports than were in effect December 31, 2010.

Participating states with less than 25 percent of fiscal year 2009 Medicaid LTSS expenditures allocated to non-institutional services and supports would receive a five percentage point increase in Federal Medicaid Assistance Payments (FMAP) applied to all Medicaid spending for home and community based services and supports during fiscal years 2012-2015. They will be expected to achieve a target of 25 percent of Medicaid LTSS spending devoted to HCBS by 2015. All other states in which less than 50 percent of Medicaid LTSS spending was for non-institutional supports would receive FMAP incentive payments of two percentage points and have a target of 50 percent spending on HCBS by 2015.

All incentive payments received by states must be used to expand the availability of Medicaid home and community based services and supports. Therefore, in addition to promoting infrastructure reforms in participating states, the balancing incentive program will directly support an increase of \$3 billion in spending for Medicaid-supported HCBS. The State Balancing Incentive Payments Program goes into effect October 1, 2011.

STATE PARTICIPATION ISSUES

Most states that meet the qualifying threshold for proportional Medicaid HCBS spending can be expected to vigorously compete to participate in the program. In essence, they will be seeking a portion of the \$3 billion in enhanced matching funds to be used in their states to increase financing for Medicaid HCBS. Among the state eligibility questions that CMS will need to clarify are:

- **Qualifying Expenditure Threshold:** Does the proportional spending threshold apply to Medicaid expenditures for all populations or does CMS have the authority to enable states to participate when the balance of HCBS spending for one target population is significantly lower than for other populations? For a variety of reasons, in most states, a much higher proportion of Medicaid LTSS spending on behalf of persons with developmental disabilities is for

community based services as compared to the proportional community spending on behalf of older persons and persons with physical disabilities.

As a result, when Medicaid LTSS expenditures for all populations are calculated, at least 9 states spend more than 50 percent on HCBS. When proportional spending is segmented by population, at least 4 states spend more than 50 percent for HCBS on behalf of older people and people with physical disabilities, while at least 39 states spend more than 50 percent for HCBS on behalf of people with developmental disabilities.¹

- **Implementation Timeline:** Can CMS extend the timeline by which states must achieve statewide implementation of the three required delivery systems reforms: establishment of a “No Wrong Door— Single Entry Point System”; adoption of conflict-free case management; and application of uniform core assessment instruments for determining eligibility for HCBS? Is it possible to establish intermediate milestones? States that have not already developed plans to adopt these reforms will find it practically impossible to have all three in place statewide within six months of submitting a balancing program application to CMS.

For example, in developing a system of LTSS access points and conflict-free case management, states would likely want to engage stakeholders in decisions that could result in significant changes to delivery systems and realignment of community agencies’ roles. They would also need to issue regulations, develop payment methodologies, negotiate contractual agreements, etc. Even in the best policy environment, all of these activities take time, and the six-month deadline specified in the ACA could discourage some states from applying.

Development of a standardized assessment instrument that can be used in a uniform manner across a state can take years to complete, based upon the experiences of states that already have one. Assessment tools must reflect each state’s distinct program eligibility criteria and collect the right information to measure it. Time is needed to test the instrument for reliability to determine whether it consistently assesses the right criteria when administered by large numbers of program staff scattered across the state. Information systems must also be created or modified to record assessment data and transmit it to state officials for tracking, reporting and policy development purposes.

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

Established by the Deficit Reduction Act (DRA) of 2005, this demonstration encourages states to identify Medicaid recipients who have been living in an institution and want to return to community living. When a state facilitates such transitions, it receives an enhanced FMAP for the Medicaid HCBS it provides to program participants during the first year of their relocation. The increased Medicaid funds states earn under the demonstration must be reinvested in their LTSS systems to expand the availability of community-based options. Thirty states are currently participating in the demonstration.

The Money Follows the Person (MFP) Demonstration was originally scheduled to end in 2011. The ACA extends it through 2016 and reduces the institutional length of stay needed to qualify for enhanced HCBS matching payments from 180 days to 90 days, minus Medicare covered rehabilitation days. This change will increase the number of persons who meet the demonstration's qualifying criteria, thereby generating additional Medicaid matching funds earmarked for expansion of HCBS. An additional \$2.25 billion is appropriated by the ACA through fiscal year 2016, bringing the demonstration's total funding to \$4 billion. These amendments became effective on April 22, 2010.

States can transition myriad populations, including older people, people with intellectual, developmental or physical disabilities, mental illness and those who have a dual diagnosis. As of December 2009, approximately 6,000 persons have transitioned to the community through MFP.² Since the broader goal of the MFP demonstration is to increase use of HCBS and reduce use of institutions, the enhanced Medicaid funds generated by the program, as well as its federally funded administrative resources, can be used to advance broader state delivery systems reforms. As part of its program application, each state establishes program benchmarks, which are specific goals for transitioning individuals from institutions, for "rebalancing" Medicaid spending for LTSS, and for improving service delivery systems.

Federal administrative funds are available to support state initiatives that help them achieve their benchmarks. To advance LTSS rebalancing, states have invested enhanced matching funds and administrative resources in initiatives such as establishing web-based portals to make information about services and supports more accessible; enhancing the availability of housing for people with long term support needs; developing LTSS systems reform plans with stakeholders; and creating LTSS community access points.

STATE PARTICIPATION ISSUES

- **New State MFP Grants:** CMS issued a grant solicitation on July 26, 2010 targeted to states that are not currently participating in the program. It received letters of intent to apply from 14 states, which would increase the number of states participating in the program to 44 if all are funded. CMS awarded applicant states planning grants of \$200,000 to facilitate their ability to develop the project application and to prepare for full program implementation upon receipt of an MFP grant award. State proposals are due to CMS on January 7, 2011.

NEW MEDICAID AUTHORITIES FOR FINANCING HOME AND COMMUNITY BASED SERVICES

The Affordable Care Act established a new optional Medicaid state plan service called the Community Choice First Option under 1915(k) of the Social Security Act. It also made several amendments to optional State Plan HCBS initially adopted by the DRA under Section 1915(i) of the Social Security Act. These two provisions add to the array of existing Medicaid authorities states can choose to adopt to finance HCBS.

Most states use the Medicaid 1915(c) HCBS waiver program to finance the core of their LTSS system. One notable exception is California, whose major HCBS program, In-Home Supportive Services, is financed through the optional Medicaid state plan service of personal assistance. When states consider whether to adopt the new Medicaid state plan options, they will assess whether these provisions improve upon the contribution their existing authorities—HCBS waivers and state plan personal assistance services—can make to expand the availability and array of Medicaid-funded HCBS.

Medicaid HCBS waivers were established in 1981 and since then, annual program expenditures have grown to more than \$33 billion in fiscal year 2009. Generally states operate distinct waiver programs targeted to persons with developmental disabilities and have either combined or separate waivers that serve older people and adults with physical disabilities. In addition, states have established waivers designed to meet specific needs of particular populations. For example, 22 states have waivers for persons with brain injury; 18 target medically frail children, 16 have waivers that provide a distinct benefit package to persons with AIDS, and others have waivers targeted to persons with specific types of developmental disabilities.³

To receive program services and supports, persons must be assessed as needing an institutional level of care. States are permitted to use the institutional financial eligibility criteria of 300% of the SSI benefit level, instead of community categorical criteria, which in most states is the SSI benefit level plus any SSI supplement a state may provide. State waiver programs cover a broad array of services and must be budget neutral, meaning that their costs cannot exceed what would have otherwise been spent for institutional care. HCBS waivers may waive Medicaid requirements for statewideness and comparability and may establish ceilings on the number of persons who can be enrolled in the program.

Medicaid state plan personal assistance can finance assistance with activities of daily living and instrumental activities for persons who meet categorical financial criteria. Thus, the income threshold to qualify for state plan personal assistance is considerably lower than for HCBS waiver services. On the other hand, federal rules do not require personal assistance recipients to need an institutional level of care. Instead, states set criteria for establishing an individual's need for services, which is typically less stringent than institutional criteria. Services must be provided statewide and to all who meet the program's eligibility criteria, meaning that program benefits are individual entitlements. Thirty-six states provide personal assistance in varying degrees through the state plan. Total expenditures for fiscal year 2009 are more than \$11 billion.⁴

In determining whether to adopt the new Medicaid authorities, states will assess the contribution each can make to improving their LTSS systems. In some instances, they may conclude that building upon their current funding authorities will best advance their system's reform priorities. The analysis that follows presents some specific examples of HCBS policies that could be implemented through the new Medicaid HCBS funding authorities enacted through the ACA.

STATE PLAN HCBS

State Plan HCBS, enacted through the DRA and authorized by Section 1915(i) of the Social Security Act, has features that make it a hybrid between a Section 1915(c) HCBS waiver program and a Medicaid state plan optional service—such as personal assistance. Similar to 1915(c) waivers, 1915(i) State Plan HCBS encompasses multiple services; however, the scope of services covered by the 1915(i) state plan option in the DRA was more limited than could be authorized through waivers.

In contrast to waiver program eligibility criteria, 1915(i) State Plan HCBS does not require persons to need an institutional level

of care—in fact, states must establish less stringent functional criteria than they use for waivers. Thus, states have not been permitted to adopt the more generous institutional income standard of 300 percent of SSI permissible under the 1915(c) waiver program. Generally participants can have income up to 150% of the federal poverty level as long as they qualify under an eligibility group covered by the Medicaid state plan.

Given these various program policies, states have not viewed 1915(i) State Plan HCBS as providing them with a vehicle for funding community based supports that improves upon the array of existing Medicaid authorities. Only a handful of states have adopted it, all of which did so for very specialized purposes, as described in the following section.

With the intent of improving 1915(i) State Plan HCBS so more states will adopt it, the ACA broadens the scope of covered services. The amendments also permit states to use this authority to serve the same population that meets both the functional and financial criteria of their existing HCBS waivers. And within the needs-based program criteria established by a state, it may offer HCBS to specific targeted populations and cover services that are different in amount, duration, and scope for different populations. These amendments modestly modify the niche that the 1915(i) State Plan HCBS could fill within state systems of long-term services and supports.

However, several other amendments make it less likely than before that states will implement 1915(i) on a broad scale. Most importantly, the ACA eliminates states' ability to control the growth of program costs through program enrollment ceilings and it requires states to offer services statewide. The amendments also specify that if a state tightens its needs-based criteria, it must continue providing coverage for persons who were eligible under the previous criteria for as long as the program is in effect. Provisions amending Medicaid Section 1915(i) are effective October 1, 2010. CMS has issued guidance requiring the five states with approved 1915(i) programs to submit state plan amendments that conform to the new statutory provisions if they want to continue providing State Plan HCBS.⁵

The evolution of State Plan HCBS underscores that public policy for LTSS is developed through a collection of disparate program authorities. They are often designed in isolation from one another but implemented within LTSS delivery systems in conjunction with other programs having both complimentary and conflicting policies. From a state perspective, one of the impediments to adopting State Plan HCBS is the interaction of its policies with those of the more predominate HCBS funding authorities.

For example, removal of the state's ability to set enrollment ceilings for the program, coupled with its less stringent needs-based eligibility criteria provides an entitlement to HCBS under this option for persons who do not meet the state's institutional level of care standard, when persons with higher needs served through 1915(c) waivers do not have such an entitlement.

Another complication arising from the ACA amendments is that if a state is forced to reduce expenditures for HCBS programs, it is largely unable to make surgical, incremental cost savings in this program. Unlike waiver programs, 1915(i) does not permit states to cap or suspend program enrollment and because of the grandfathering provision, it does not permit states to tighten needs-based eligibility criteria in a way that would affect current enrollees. Therefore, states' options in the face of severe program cutbacks would be to either take all program reductions from 1915(c) waiver programs, which serve a higher need group, or eliminate 1915(i) altogether.

SCENARIOS FOR STATE ADOPTION

No state is likely in the near future to adopt 1915(i) to provide new HCBS coverage for a broad based group of individuals who do not have an institutional level of care need. Only until a state has fully covered all persons who meet the financial and institutional level of care criteria of its current HCBS programs would it be likely to consider extending large scale coverage to a population with less intensive needs. However, some states might adopt 1915(i) on a limited basis as the following scenarios illustrate.

- **Finance Disallowed Rehabilitative Services:** States could continue to adopt 1915(i) as a vehicle for maintaining Medicaid financing for services that have been disallowed continued coverage under their state plan rehabilitative services option, as three of the five states with current 1915(i) options have done. The first two states to adopt 1915(i), Iowa and Nevada, primarily covered services targeted to people with serious mental illness and as a result, State Plan HCBS became characterized as a vehicle for Medicaid coverage of mental health services. However, Iowa's and Nevada's adoption of State Plan HCBS was not a deliberate strategy to finance mental health services. Rather, it was a way to maintain Medicaid financing for federally disallowed components of their states' rehabilitative services option that just happened to be mental health services.

For the past five years or so, the DHHS Inspector General and CMS have focused attention on services states cover under the Medicaid rehabilitative option. In 2007, CMS is-

sued proposed rules that defined both the allowable scope of rehabilitative services and excluded coverage. The resulting outcry from a wide range of stakeholders led Congress to issue a moratorium on their implementation. However, CMS continued to apply the proposed coverage definitions on a state-by-state basis when states submitted unrelated state plan amendments or through general program reviews. Among the types of services that have been disallowed are habilitation services that help people acquire new functional abilities (in contrast to allowable rehabilitative services that focus on restoring functional levels), services that provide general support and supervision, and services to help people maintain functional levels.

As result of a DHHS Inspector General's audit that disallowed some of the services provided under its rehabilitative option, Iowa developed a 1915(i) state plan amendment to protect Medicaid coverage of habilitation services for persons with chronic mental illness. Nevada adopted 1915(i) to maintain Medicaid financing for partial hospitalization services for individuals with chronic mental illness, habilitation services, and adult day health care—all of which were disallowed continued coverage under the state's rehabilitative service option. And more recently, Washington adopted 1915(i) to replace Medicaid financing for adult day health care previously provided as a rehabilitative service.

It is unclear whether CMS is continuing to actively review states' coverage of rehabilitative services. In November 2009, it officially withdrew the proposed rules issued in 2007. But if certain services continue to be disallowed on a state-by-state basis, 1915(i) can remain the replacement vehicle for Medicaid funding. Since these services would have already been provided under the state plan, 1915(i) coverage would not create a new entitlement. However, since the ACA prohibits states from applying any changes in need-based criteria to current recipients of 1915(i) services, states might tighten the criteria they used under the rehabilitative services option when establishing initial 1915(i) coverage. Using 1915(i) as an alternate coverage vehicle does not result in an expansion of HCBS, but it does allow states to maintain current service availability.

- **Provide Mental Health Services:** States could adopt 1915(i) to provide HCBS to populations difficult to cover under 1915(c) waivers, such as persons with mental illness. Persons aged 21-64 who require an institutional level of care primarily due to serious mental illness and who do not meet

the state's criteria for nursing home admission would not be eligible for 1915(c) waiver services because they would not have otherwise received Medicaid-funded institutional services. For persons in this age group, Medicaid does not cover services provided in institutions for mental disease (IMDs). Therefore, the provision of waiver services is not viewed as diverting an institutional placement as it would not have been covered in the first place.

Wisconsin has adopted 1915(i) to provide services to persons with serious and persistent mental illness. The covered benefit is psychosocial rehabilitation/community recovery services and consists of three parts: community living supportive services, supported employment, and peer supports. Medicaid funding under 1915(i) is replacing county resources that previously funded community living supportive services and is providing new coverage for supportive employment and peer supports. Wisconsin is submitting to CMS a new 1915(i) amendment to conform with the ACA provisions that require statewide coverage and elimination of program enrollment ceilings. To afford that service expansion, Wisconsin's new 1915(i) program will tighten the needs-based eligibility criteria it adopted prior to enactment of the ACA amendments. Given states' fiscal conditions, 1915(i) might increasingly be used to fund mental health services previously supported by state or county resources.

- **Target a Priority Population:** States could adopt 1915(i) to provide a specific HCBS benefit to a priority population that does not need an institutional level of care but could be a tightly defined target population under a narrow needs-based set of criteria. This approach would contain a state's risk of rapid program cost growth and still address the service needs of a priority population. If a state has not maximized enrollment in its 1915(c) waivers, it would want to consider whether financing supports for the new population under 1915(i) is a higher priority than providing HCBS for persons with an institutional level of care who are on wait lists for waiver services.

If a state has identified a narrowly defined population who require an institutional level of care, in almost all instances, a more judicious choice would be to create a specialized HCBS waiver program or amend an existing waiver to incorporate services that address this population's needs.

COMMUNITY FIRST CHOICE OPTION

This new Medicaid state plan option finances home and community based attendant services and supports to assist eligible persons accomplish activities of daily living, instrumental activities of daily living, and health-related tasks. Program services also include acquisition of skills to accomplish daily living activities, back-up systems, and voluntary training for managing attendants. Permissible supports are expenditures for items such as one month's rent, utility deposits, and household furnishings to help individuals transition from institutions, and expenditures that increase independence or substitute for human assistance. Specifically excluded are expenditures for assistive technology devices (other than those that can substitute for human assistance), medical supplies and equipment, home modifications, and vocational rehabilitation.

Attendant services and supports may be provided by agencies or through alternative models such as vouchers, direct cash payments or fiscal agents and are controlled by the individual. States are to develop and implement Community First Choice Option in collaboration with a Development and Implementation Council that has a majority membership of persons with disabilities, older people, and their representatives.

Financial eligibility for Community First Choice Option is defined in a manner similar to that of State Plan HCBS, using a two-tiered approach. One set of individuals are those who are financially eligible for medical assistance under the state plan and have income of less than 150% of the federal poverty level. The other group has income applicable for an individual who has been determined to require an institutional level of care (typically 300% of SSI) and meets the institutional level of care criteria.

This state plan option adds to the existing Medicaid authorities states can use to finance LTSS for older people and persons with disabilities. In comparison to Medicaid HCBS waiver policy, Community First Choice Option does not mandate budget neutrality, meaning that state spending is not held to an amount that would have otherwise been spent for institutional care. States cannot set ceilings on the number of persons who can receive supports or offer benefits on less than a statewide basis, as they can under HCBS waivers. Thus, Community First Choice Option establishes an individual entitlement to a broad definition of attendant services and supports provided without regard to the individual's age, type or nature of disability, or the form of home and community based attendant services and supports that the individual requires to lead an independent life.

States adopting this option will receive a six percentage point increase in their FMAP rate for Community First Choice Option expenditures. During the full fiscal year in which an attendant services and supports state plan amendment is implemented, a state must maintain the same level of Medicaid expenditures for individuals with disabilities or elderly individuals as in the previous year. Community First Choice Option becomes effective on October 1, 2011.

SCENARIOS FOR STATE ADOPTION

States will continue making new investments in HCBS systems as state economies begin to improve. For reasons previously discussed, 1915(c) HCBS waivers will likely be the vehicle of choice for most states. However, in a specific set of circumstances, a state may be in a position to consider adopting Community First Choice Option.

- **Adoption Strategy:** Community First Choice Option establishes an individual entitlement, and conversely does not give states the ability to control program growth through budgeted enrollment levels. States that could realistically afford this option are ones that fully serve all persons eligible for all of their HCBS waivers; already provide a generous state plan personal assistance benefit to persons who do not need an institutional level of care; and have a high proportion of total LTSS expenditures devoted to HCBS. States with this set of circumstances would already be providing HCBS in a non-entitlement context to most people who would be entitled to Community First Choice Option.

What is not known is how the cost of this program's benefit would compare with the average per-person cost of the supports provided through a state's existing HCBS programs. The benefit appears to be drafted expansively. CMS guidance may articulate the parameters for defining it, which could be a policy lever states could use to make adoption of the program more affordable. Upon completing a fiscal analysis, a state might be willing to assume that the 6 percent enhanced match could cover any higher per-person benefit cost, or off-set the risk of uncontrolled expenditure growth.

If a state determines it is unable to make the financial commitment required to adopt Community First Choice Option, it could at a minimum seek to incorporate its well-articulated underlying philosophy and principles into the operation of its existing HCBS programs. In addition, to provide participants in existing Medicaid

HCBS programs with some of the opportunities for participant direction available under Community First Choice Option, states could adopt Section 1915(j) of the Social Security Act, Medicaid Self-Directed Personal Assistance.

The DRA of 2005 gave states a new authority for providing self-directed personal assistance services. If a state amends its Medicaid state plan to offer persons the option to self direct personal assistance, individuals have employer and budget authority. This means they can hire, train, supervise, manage and fire their providers, and can direct the purchase of personal assistance from funds in their individualized budget. At the State's option, individuals may also "save" funds in their budgets to purchase goods or services that increase their independence or substitute for human assistance, to the extent expenditures would have been made for human assistance. States can adopt this authority for personal assistance provided under a 1915(c) HCBS waiver or under its state plan personal assistance service. To date, eight states are implementing section 1915(j) state plan amendments

STATE IMPLEMENTATION OF LONG TERM SERVICES AND SUPPORTS REFORMS

States recognize that their LTSS systems need to provide greater opportunities for individuals to get the services and supports they need to live where they prefer to live—in their own homes and communities. Most have been steadily implementing policies to both expand Medicaid financing for HCBS and reform delivery systems to enhance consumers' access to an expanded and diversified array of supports. Yet progress across the country has been uneven, with a few states achieving an equal balance of Medicaid spending between HCBS and institutional services while other states are far behind.

The State Balancing Incentive Payments Program will provide states with significant support in moving forward reforms to expand HCBS. Likewise, fourteen additional states are likely to participate in the Money Follows the Person Demonstration. And all MFP grantee states will benefit from recent CMS policies that bolster the ability of the program to support state rebalancing initiatives along with facilitating transitions of institutional residents to community living. States will eagerly adopt these ACA provisions.

States have significant roles in implementing practically all aspects of the ACA, ranging from regulating private insurance reforms, establishing health exchanges, structuring significant Medicaid

eligibility expansions, and adopting health delivery system and payment reforms. Within this context, states will consider LTSS systems reforms. The state leadership of the National Academy for State Health Policy has identified “focus on the dually eligible” as one of the 10 aspects of federal health reform that states must get right if they are to be successful in implementation.⁶

To achieve more comprehensive reforms in the financing and delivery of LTSS, states are also looking to several other provisions of the ACA. The Federal Coordinated Health Care Office—known colloquially as the Duals Office—is charged with a broad agenda for improving coordination between the Medicare and Medicaid

programs on behalf of dual eligibles. Providing support to state efforts for coordination of health and LTSS for duals is one of its specific responsibilities. The Center for Medicare and Medicaid Innovation, also located within CMS, provides great promise for advancing demonstrations to test innovative payment and delivery systems reforms that will improve care coordination across a broad spectrum of chronic care services. Working together, state and federal governments and stakeholders have a new opportunity to design significant initiatives that will improve the financing and delivery of health and long term care services to persons with the most complex needs.

ENDNOTES

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- 2 Centers for Medicare and Medicaid Services, Center for Medicaid, CHIP, and Survey & Certification, State Medicaid Directors’ Letter SMDL# 10-012. June 22, 2010. <http://www.cms.gov/smdl/downloads/SMD10012.pdf>
- 3 Steve Eiken, Brian Burwell, Lisa Gold and Kate Sredl, “Medicaid HCBS Waiver Expenditures: FY 2004 Through FY 2009,” Thomson Reuters, August 17, 2010; available at www.hcbs.org/moreInfo.php/doc/3326
- 4 Eiken, et al. “Medicaid Long Term Care Expenditures in FY 2009” www.hcbs.org/moreInfo.php/doc/3325
- 5 Centers for Medicare and Medicaid Services, Center for Medicaid, CHIP, and Survey & Certification, State Medicaid Directors’ Letter SMDL# 10-015. August 6, 2010. <http://www.cms.gov/smdl/downloads/SMD10015.pdf>
- 6 Alan Weil, “State Policymakers’ Priorities for Successful Implementation of Health Reform,” National Academy for State Health Policy, May 2010; available at http://nashp.org/sites/default/files/policymaker_0.pdf

NATIONAL ACADEMY for STATE HEALTH POLICY

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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Portland, Maine Office:

10 Free Street, 2nd Floor, Portland, ME 04101
Phone: [207] 874-6524

Washington, DC Office:

1233 20th Street NW, Suite 303, Washington, DC 20036
Phone: [202] 903-0101