



Patient Protection and Affordable Care Act

New Options for Long-Term Services and Supports

Title II – Role of Public Programs

Subtitle E – New Options for States to Provide Long-Term Services and Supports (LTSS)

Title III, Sub. E of the Patient Protection and Affordable Care Act (P.L. 111-148) includes multiple provisions related to improving Long Term Services and Supports (LTSS) for people with disabilities of all ages. These provisions, described below, will not only increase independence, choice, and the ability to receive services in the community, but they also have the potential to reduce Medicaid costs and save states money over time.

Community First Choice Option (CFC)

Section 2401 amends Sec. 1915 of the Social Security Act to include a new state plan option, available beginning October 1, 2011, to provide comprehensive home and community-based attendant services and supports for individuals who are eligible for an institutional level of care. State adoption of the CFC option would support the *Olmstead* decision by giving people the choice to leave facilities and institutions for their own homes and communities with appropriate, cost effective services and supports. It would also help address state waiting lists for services and correct the institutional bias in Medicaid by providing access to a community-based benefit. The option would not allow caps on the number of individuals served, or waiting lists for applicable services. Due to budget crises in many states, Medicaid benefits are being cut. As an incentive to participate, states that adopt the CFC option will be eligible for an additional six percent federal match rate for included services.

States that choose to provide services under the option will be required to make home and community-based attendant services and supports available to eligible individuals to assist them with activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. Activities of daily living include eating, toileting, grooming, dressing, bathing, and transferring. Instrumental activities of daily living include: meal planning and preparation; managing finances; shopping for food, clothing, and other essential items; performing essential household chores; communicating by phone and other media; and traveling around and participating in the community. Health-related tasks are defined as those tasks that can be delegated or assigned by licensed health-care professionals under state law to be performed by an attendant. Services also include assistance in learning the skills necessary for the individual to accomplish these tasks him/herself, back-up systems, and voluntary training on selection and management of attendants. Certain expenditures would be

excluded, including room and board, services provided under IDEA and the Rehabilitation Act, certain assistive technology devices and services, durable medical equipment and home modifications.

Services provided under the option must be made available statewide in the most integrated setting appropriate for the individual. Services must be provided regardless of age, disability, or type of services needed. Service delivery models must include consumer directed, agency-based, and other models, along with requirements to comply with all federal and state labor laws. CFC services would not affect the state's ability to provide such services under other Medicaid provisions.

States that participate are required to establish a Development and Implementation Council to work with the state in developing and implementing the state plan amendment necessary in order to provide the services. The majority of Council members must be individuals with disabilities, elderly individuals, and representatives of such individuals, and must collaborate with, among others, providers and advocates.

Removal of Barriers to Providing Home and Community-Based Services (HCBS)

The existing HCBS state plan option (Sec. 1915(i) of the Social Security Act) allows states to provide HCBS services without a waiver, but states must establish eligibility criteria that is less strict than that for institutional and HCBS waiver services. However, very few states have taken up this option due to several limitations. The new law reforms "little (i)" to align the income eligibility criteria with other HCBS programs. The following changes to remove barriers to HCBS would ensure that individuals receiving services will not lose them if states change their eligibility requirements (as long as those individuals are eligible under the existing criteria). The options do not allow for enrollment caps or waiting lists, thus all those eligible must receive services. Benefits under the main option (1915(i)) would be available statewide, and states can cover more services to meet individual needs and keep them out of institutions. The changes also make more people within the income limit eligible for services. The effective date of these changes appears to be April 1, 2010.

Section 2402 requires oversight and assessment of the administration of home and community-based services (HCBS) and allows additional state options to provide HCBS. Under this section, states must develop service systems that are designed to allocate resources in a manner that is responsive to the changing needs and choices of HCBS recipients; provide support to beneficiaries to design an individualized, self-directed, community-supported life; and improve coordination among, and the regulation of, all providers of such services under federally and state-funded programs. This section also creates the following state options to provide HCBS:

Option to offer HCBS for Individuals Eligible for Services under a Waiver

States who are taking up the HCBS state plan option now have an option to provide HCBS to individuals who are eligible for services under a waiver and have incomes up to 300 percent of the Supplemental Security Income benefit rate. States have the authority to vary the type,

amount, duration and scope of HCBS under the option from that provided under the overall state plan option.

Option to offer HCBS to Specific, Targeted Populations

States may also target HCBS to specific populations, and can vary the type, amount, duration and scope of HCBS offered to those populations. The election to target populations lasts for five years (but is renewable) and states can phase in services and eligibility during the initial five-year period. States can vary the type, amount, duration and scope of HCBS provided to these targeted groups.

Optional Eligibility Category to Provide Full Medicaid Benefits

States may provide full Medicaid benefits to individuals receiving HCBS under the state plan option effective on the first day of the first fiscal year quarter after the enactment date.

Money Follows the Person Rebalancing Demonstration

Section 2403 extends the Money Follows the Person Rebalancing Demonstration program through 2016 and allows states to cover people who are institutionalized for over 90 days.

Protection for Recipients of HCBS against Spousal Impoverishment

Medicaid permits nursing home residents' spouses to keep one-half of the couple's assets, up to a ceiling. The maximum monthly income allowance is about \$2,700, while asset allowances range from about \$22,000 to \$110,000. Section 2404 will apply those same rules to spouses of individuals receiving HCBS, helping to avoid spousal bankruptcy; keep families intact; and prevent incentives for divorce, lawsuits, and other serious conflicts.

Funding to Expand State Aging and Disability Resource Centers (ADRCs)

Section 2405 appropriates \$10 million each year from 2010 to 2014 to the Aging and Disability Resource Centers to carry out their prescribed purposes.

Title VIII – Community Living Assistance, Services and Supports (CLASS) Act

Title VIII creates a new national long-term care insurance program, the Community Living Assistance, Services and Supports (CLASS) Act, to help adults who have, or develop, functional impairments to remain independent, employed, and engaged in their community. Most people who need long-term services and supports (LTSS) have few options for financing their care; many rely on their own resources or help from family members because private long-term care insurance is too expensive or is denied based on pre-existing conditions. While CLASS benefits may not cover the cost of all long-term care needs, they will help those who can continue to work to do so, thus allowing people with disabilities to maintain functional lives in their homes and communities and preventing or delaying the need for institutional care. The program takes effect January 1, 2011, but the Secretary of Health and Human Services has until October 2012 to develop the program. Enrollment will likely begin in 2013.

Participation

Financed by voluntary payroll deductions, enrollment in the CLASS program will be available to full and part-time working adults (at least 18 years old). Self-employed individuals and those whose employer declines to offer CLASS Act coverage will be able to sign up through a separate mechanism. CLASS is an opt-out program – if an employer chooses to participate, employees will be automatically enrolled unless they specifically decline. Spouses of working adults must meet all of the participation requirements on their own.

Participants must pay premiums for five years before they can receive a benefit. For three out of those five years, participants must earn enough to qualify for one quarter of Social Security coverage, which, in 2010, is about \$1,100.

Premiums

Premiums will vary by age (younger enrollees pay less than older enrollees), but not by medical condition, income or other factors. The program is not means-tested – there will be no limits on individual income or assets and the individual could continue to work. The program does not allow medical underwriting and exclusions based on pre-existing conditions (as found in private insurance plans). As a result, many people who could not afford, or would be denied coverage for, private long-term care insurance can access LTSS coverage through CLASS.

The law does not specify CLASS premium amounts, but directs the Secretary of Health and Human Services to establish premiums at a level that ensures the program's solvency for 75 years. The Congressional Budget Office assumed average premiums of \$123 a month in its cost estimate of CLASS, but the premiums will be less if many people enroll. Additionally, full-time students who are working and persons with incomes below the federal poverty level will pay nominal premiums, starting at only \$5 a month.

In general, premiums will remain level for enrollees. Premiums will only increase if the Secretary determines that an increase is necessary to maintain program solvency or if a participant lapses payment for more than three months and later wishes to enroll. Such participants who drop out and re-enroll will have their premiums adjusted for their age at the time of re-enrollment, and must pay premiums for 24 consecutive months before receiving a benefit. A participant who re-enrolls after a lapse of more than five years will face a penalty as well as a premium increase.

Benefits

To receive a benefit, a participant must have paid premiums for five years, worked for three of those five years (earning enough to qualify for one quarter of Social Security coverage), and have a functional limitation, certified by a licensed health care practitioner, that is expected to last for at least 90 continuous days. The limitation could be either: a limitation in at least two or three activities of daily living (such as eating, bathing, and dressing); a cognitive impairment that requires substantial supervision to protect the person from threats to health or safety; or a similar level of functional limitation.

After the determination of eligibility, a recipient will have access to a cash benefit, not lower than \$50 per day, provided through a debit card. Benefits are expected to average \$75 per day, but the actual cash benefit will depend on the person's level of impairment – higher benefits will be paid to those with a higher level of impairment. Benefits may be paid on a daily or weekly basis. The Secretary has the discretion to determine a maximum benefit amount, but benefits are not subject to any lifetime or aggregate limit. Benefits will rise with inflation and continue for as long as the individual needs care. Counseling services will also be available to every beneficiary. Participants must continue paying premiums to continue receiving benefits. A person may stop working after meeting the three-year work requirement, as long as he or she continues to pay premiums.

The CLASS program seeks to empower consumers: its flexible benefit could be utilized to meet an individual's particular needs, such as paying for personal assistance services, assistive devices or equipment, respite care or even institutional care. Benefits could even be rolled over from month to month (for up to 12 months) to pay for more expensive items, such as home modification. CLASS benefits may not cover all of the costs of long-term care, thus participants may wish to supplement its benefits with private long-term care insurance, other public and private programs or personal resources.

CLASS and Medicaid

CLASS benefits do not affect eligibility or continuing eligibility for benefits under any other federal, state or locally funded assistance program. CLASS enrollees who qualify for Medicaid will retain some CLASS benefits, but CLASS would be the primary payer and Medicaid would be the secondary payer in such an instance. Medicaid recipients in nursing homes may retain five percent of their CLASS benefits; those who receive HCBS may retain 50 percent, which could pay for additional services and supports.

A state can only receive the remaining 50 percent of CLASS benefits for HCBS if the provision of these services through a waiver or state plan amendment does not include a waiver of statewideness or

comparability and offers, at a minimum, case management services, personal care services, habilitation services, and respite care.

Solvency and Effects

The new law includes safeguards to ensure that no taxpayer dollars will be used to pay benefits and that the program will be solvent for at least 75 years. It also includes language that allows the Secretary of Health and Human Services to provide additional solvency safeguards if necessary.

Because CLASS benefits offset some Medicaid costs and may help prevent or delay the need to spend down in order to become eligible for Medicaid, the Congressional Budget Office found that the CLASS program will result in Medicaid savings of about \$2 billion in the initial benefit-paying years. CBO also estimated that the CLASS Act will reduce the federal deficit by \$70.2 billion over ten years. Going forward, it will be important to monitor the affordability of premiums and the adequacy of CLASS benefits, as well as participation rates, that will impact the solvency of the program.

**Title X – Strengthening Quality, Affordable Health Care
For All Americans**
Subtitle B, Part I – Medicaid and CHIP

New State Balancing Incentives Payments Program

Section 10202 aims to replicate the success of states like Washington and Oregon by focusing on diversion from institutions. Under the new program, States that make structural reforms to increase diversion from institutions and expand the number of people receiving HCBS are eligible to receive a temporary FMAP increase from October 1, 2011 through September 30, 2015. Federal grants of up to \$3 billion would be available during that period. In order to receive funds, states must apply, meet certain eligibility criteria and be selected by the Secretary of Health and Human Services. Within six months, a selected state will need to adopt: a single point of entry system, case management services, a standardized assessment instrument for determining eligibility, a system for monitoring capacity, and a data collection infrastructure. Grant funding will be targeted to states that spend less than 50 percent of their LTSS funds on HCBS services in an effort to increase total HCBS spending. States that spend less than 25 percent of total LTSS spending on HCBS will get a five percent FMAP increase with a target of bringing spending up to 25 percent by 2016. States spending 26 to 50 percent on HCBS will get a two percent FMAP increase with a target of bringing spending up to 50 percent by 2016.