

Health Care Reform Improves Access to Medicaid Home and Community-Based Services

Health care reform legislation recently signed into law will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at parts of the new law that provide new financial incentives for states, and creates opportunities within existing programs, to promote Medicaid home and community-based services (HCBS) for older persons and adults with disabilities.

Health Care Reform Provides HCBS Balancing Options and Incentives

The majority of older persons and adults with disabilities say that they prefer to remain in their home and community. Despite this preference, Medicaid—the primary payer for long-term services and supports (LTSS)—spends more of its long-term care (LTC) dollars on institutional services than on home and community-based services (HCBS). Many states, however, have been moving toward a more balanced mix of institutional and HCBS, although the pace of change varies quite substantially across states.

The new health care reform law provides opportunities for states to improve the balance between institutional and HCBS, even in the current tight fiscal environment. It does so in two broad ways. First, the bill creates two new Medicaid initiatives that offer financial incentives to states to improve access to HCBS. Second, it modifies existing Medicaid and other provisions to facilitate and extend opportunities for older persons and adults with disabilities to receive HCBS.

The number and variety of new options, combined with the prospect of additional

federal funds, may give some states added flexibility in balancing their LTC system. In some circumstances, however, states must maintain certain HCBS spending levels or eligibility requirements in order to qualify for the additional federal funds. Maintaining current funding or eligibility levels may present a challenge to some cash-strapped states.

New Programs

The legislation creates two financial initiatives:

- The Community First Choice option
- The State Balancing Incentive Payments Program

Community First Choice (CFC) Option

The CFC option is a new Medicaid state plan option that covers HCBS attendant services and supports to Medicaid-eligible individuals with institutional level of care need. States that take up this option will receive an increase in their federal Medical Assistance Percentage (FMAP) of 6 percentage points for expenditures related to the option. The option begins in October 2011.

Requirements of the Option

States must meet a number of requirements under the option.

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First, states must maintain or exceed HCBS expenditures for older persons and adults with disabilities in the first full fiscal year the option is implemented.¹

Second, states must offer services statewide and may not impose waiting lists or other enrollment restrictions on eligible individuals.

Third, states must provide certain HCBS attendant services and supports. These services and supports must be based on a person-centered plan of service and under an agency-provider or other model, in which attendant services are managed and controlled to the maximum extent possible by the recipient or recipient's representative.

Covered services must include assistance in accomplishing and the acquisition, maintenance, and enhancement of skills to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks. Services must also include back-up systems for continuity of services and supports and voluntary training on the selection and management of attendants.

States may also choose to cover the cost of transitioning from an institution to the community, or services that increase independence and substitute for human assistance. The option would not cover room and board costs, home modifications, medical supplies, and other specified services.

Other requirements include establishing and maintaining a comprehensive, continuous quality assurance system, and establishing a Development and Implementation Council, a majority of whose members are individuals with disabilities, older adults, and their representatives.

Who Can Qualify?

States have some flexibility to set income eligibility levels under the option.

States may choose an income level up to 150 percent of the federal poverty level (FPL). Alternatively, a state may choose a higher income level if, under the State plan, a higher level applies for persons who require institutional level of care to be eligible for Medicaid services.

Consequently, states may enroll individuals up to their state's Special Income Limit, which may be 300 percent of the Supplemental Security Income (SSI) benefit amount in some states, or through the medically needy program.

State Balancing Incentive Payments Program

The Balancing Incentive Payments Program provides a five-year grant to states that spent less than 50 percent of their Medicaid LTC dollars on non-institutional services and supports. Funding will be available from October 1, 2011, to September 30, 2015.

The grant amount will vary depending on the state's balance of spending between institutional and non-institutional services.

Qualified states that spent less than 25 percent of their total 2009 Medicaid LTC dollars on HCBS will be eligible for an enhanced FMAP of 5 percentage points. Qualified states that spent at least 25 percent but less than 50 percent of their total 2009 Medicaid LTC dollars on HCBS will be eligible for an enhanced FMAP of 2 percentage points.

The statute gives the Secretary of Health and Human Services broad authority to establish definitions that may differ from those specified in the statute.

Definitions of qualifying states and qualifying expenditures for purposes of the grant could change and affect state

eligibility to participate in the program. The Secretary will be providing additional clarity as this provision is implemented.

Requirements of the Program

There are three main requirements for the grant.

First, states must implement structural changes to their Medicaid program that will expand and diversify non-institutional services. These changes must include the development of a statewide single entry point system (“No Wrong Door”), conflict-free case management services, and core standardized assessment instruments for eligibility determination.

These changes have to be in place within six months following the application for the grant. States must also collect certain data.

Second, states must commit to improve the balance of spending between HCBS and institutional services and meet targeted spending levels by October 1, 2015. States that have spent less than 25 percent of their total 2009 Medicaid LTC budget on HCBS must achieve a target of 25 percent by October 1, 2015. States that have spent at least 25 percent but less than 50 percent of their total 2009 Medicaid LTC budget on HCBS must achieve a target of 50 percent by October 1, 2015.

Third, states must use the additional federal funds under this program for new or expanded Medicaid non-institutional services and supports. In addition, states must maintain eligibility standards, procedures, or methodologies that were in place on December 31, 2010.²

Who Can Qualify?

States may expand coverage under the program to Medicaid recipients who qualify through existing eligibility pathways. For instance, states could expand through waiver services, Personal Care Services, or through the

Medicaid HCBS state plan amendment option (as described below).

If the state chooses to expand coverage through the Medicaid HCBS state plan amendment option, the state may establish a higher income eligibility level than currently offered under the state plan amendment. States may enroll individuals whose income is up to 300 percent of SSI (rather than the current 150 percent of FPL).

States choosing this option also may enroll individuals using less stringent needs-based eligibility criteria than those used for institutional services. This is a requirement of the Medicaid state plan amendment option for HCBS.

Modifications to Existing Programs

The new legislation also improves access to HCBS by doing the following:

- Modifying the existing 1915(i) Medicaid state plan amendment option for HCBS to enable states to extend full Medicaid benefits to HCBS participants through the state plan amendment. States are given added flexibility in the type, scope, and duration of services they may offer, as well as the ability to target services to specific populations. States are also given the flexibility to offer expanded services, subject to approval from the Centers of Medicare and Medicaid Services. States must provide services statewide and may not place caps on enrollment.
- Extending funding and authority for Aging and Disability Resource Centers (ADRCs), which are one-stop, single-entry access to LTSS administered by the Administration on Aging. ADRCs are authorized and funded for an additional five years at \$10 million each year from 2010 to 2014.

- Extending funding and authority for the Money Follows the Person (MFP) Rebalancing Demonstration program. MFP enables available funds to move with the person to the most appropriate and preferred setting. MFP is authorized and funded for an additional five years at \$450 million each year from 2012 to 2016.

The new legislation also reduces the eligibility requirement for MFP from a minimum stay of six months to a stay of 90 consecutive days in a nursing home. Nursing home days solely for short-term rehabilitation will not count toward the 90-day minimum required stay.

- Requiring states to extend income and asset protections for spouses of Medicaid HCBS recipients so that a spouse of a disabled person is not forced to spend all of the couple's resources to Medicaid eligibility levels so that the disabled spouse can qualify for Medicaid (also known as spousal impoverishment protection). Currently, states are required to extend spousal impoverishment protections only to Medicaid recipients in nursing homes. States

have the option but are not required to extend these protections to spouses of HCBS recipients. This new provision begins in 2014 and expires after five years.

¹ Specifically, the legislation requires maintaining or exceeding expenditures under Sections 1905(a), 1915, and 1115.

² States receiving Medicaid fiscal relief under the American Recovery and Reinvestment Act (ARRA) of 2009 are required to maintain the same Medicaid eligibility requirements that were in effect on July 1, 2008. The ARRA Medicaid maintenance of eligibility requirement extends until December 31, 2010. Thus, the maintenance of eligibility requirement under the Balancing Incentive Program requires states to apply eligibility standards that were in effect on July 1, 2008.

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