

LONG-TERM SERVICES AND SUPPORTS: CHALLENGES AND OPPORTUNITIES FOR STATES IN DIFFICULT BUDGET TIMES

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Long-term services and supports (LTSS) are defined as the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. More than 3 million people in the United States rely on Medicaid for LTSS in both nursing home and home and community-based services (HCBS) care settings. In 2009, Medicaid spending on community-based LTSS totaled \$51 billion and accounted for 44.8 percent of total LTSS spending.

Over the past few decades, the movement in this arena has moved away from institutional care (i.e., nursing homes) as the regular site for delivery of those support services, and toward community and home-based programs. That “rebalancing” can help states reduce costs and support consumer choice. States have utilized a variety of innovations to rebalance their LTSS services. However, the current fiscal struggles from the recession, including an expected \$187 billion budgetary shortfall in FY2012, have seriously restricted the ability of states to expand or maintain existing community-based LTSS.

Even with current fiscal and structural challenges, states have continued to make some progress in LTSS including:

- Creating global budgets for LTSS, and using consumer-directed programs;
- Integrating behavioral health supports into other LTSS services; and
- Enrolling dual eligibles into care coordination programs.

The Affordable Care Act (ACA) includes a number of new funding opportunities and financial incentives to expand community-based LTSS systems, notably for dual eligibles, people who qualify to receive benefits from both the Medicaid and Medicare programs. There are also a number of other programs and grants states could use to support innovation and maintain their progress in LTSS rebalancing. States will still have to overcome a number of serious challenges to move forward, but should consider ways to continue to maintain the progress they have made.

Introduction

An effective system of long-term services and supports (LTSS) is essential to enable older adults and persons with disabilities to live independently in the community. As the baby boomer generation ages, the demand for high quality LTSS is expected to grow.

More than 3 million people in the United States rely on Medicaid for LTSS, defined here as the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.¹ For those with extensive needs, Medicaid covers care in nursing homes. For *such* individuals who prefer to remain in the community, Medicaid can provide personal assistance and attendant care, home health services, homemaker services, adult day health, assistive technologies, respite care, assisted living, case management *and many more optional services*. In 2009, Medicaid spending on community-based LTSS totaled \$51 billion and accounted for 44.8 percent of total LTSS spending.² Even though the federal government shares Medicaid costs with the states, the burden on states is substantial and certain to increase.

Historically, states have been the innovators in designing new models for the delivery and financing of LTSS. Although the economic recovery is projected to continue to be slow, the Patient Protection and Affordable Care Act of 2010 (ACA) creates an array of new innovations that could enable states once again to test new models for the delivery of LTSS. This issue brief discusses the challenges and opportunities that states confront in the current budget climate in expanding their LTSS systems for seniors, adults with physical disabilities, and individuals at risk of nursing home placement.³

Long-Term Services and Supports: A Historical Perspective

Passage of the Americans with Disabilities Act (ADA) in 1990—which prohibited discrimination based on disability—was an important milestone in the movement to rebalance publicly-funded LTSS. Under Title II of the ADA, state and local governments cannot deny access to public services to people with disabilities or deny participation in programs or activities that are available to people without disabilities.⁴ States were further challenged to provide services “in the most integrated setting appropriate to the needs of qualified individuals with disabilities” when the Supreme Court upheld the “integration mandate” of the ADA on June 22, 1999, in *Olmstead v. L.C. and E.W.*⁵ The Court suggested that states might demonstrate compliance by developing comprehensive, effectively working plans” (Olmstead Plans) to reduce institutionalization, increase access to community-based services, and ensure that waiting lists for services move at a “reasonable pace.” On June 22, 2009, the tenth anniversary of the Olmstead decision, the Obama Administration launched “The Year of Community Living.” Since then, the Justice Department has embarked on an aggressive campaign to enforce the law and ensure that people with mental illness and *other* disabilities are *afforded a home and community-based services alternative to institutions*.⁶

1 Kaiser Commission on Medicaid and the Uninsured. (2010, October). Medicaid and Long-Term Care Services and Supports. Washington, D.C.: Kaiser Family Foundation.

2 Thomson Reuters. (2010, August 17) Medicaid long-term care expenditures FY 2009. Retrieved from <http://hcbs.org/moreInfo.php/nb/doc/3325/>.

3 This issue brief does not address LTSS for the population with developmental and intellectual disabilities. While states have made significant progress in rebalancing LTSS from institutional care to community-based care for this population, there is still much to be done. ACA can support system change for this population as well.

4 42 U.S.C. § 12101.

5 Smith, J.D.E., & Calandrio, S.P. (2001). Forward to fundamental alteration: Addressing ADA Title II integration lawsuits after *Olmstead v. L.C.* *Harvard Journal of Law & Public Policy*. 24(3), 695-769.

6 Miller, A. (2010, October 21). Justice Department Pushes for Services to Move Patients Out of Mental Hospitals. Kaiser Health

Before passage of the ADA and the Olmstead decision, state Medicaid agencies had three primary tools for providing LTSS:

- Home health—a mandatory benefit for adults assessed to need nursing home level of care
- Personal care—an optional state plan benefit authorized in 1978
- Section 1915(c) HCBS waivers—authorized under Section 2176 of the Omnibus Budget Reconciliation Act of 1981

In 2009, states operated 269 HCBS waivers that served 1.1 million participants at a cost of \$25 billion.⁷

Also supporting the development of LTSS was the Older Americans Act of 1965, which created a national aging network comprised of the U.S. Administration on Aging, State Units of Aging, and Area Agencies on Aging (AAAs) at the local level as part of its charge to ensure equal opportunity to health care and LTSS.

Since the Olmstead decision, the federal government has approved a number of new authorities and appropriated funds for demonstrations that have sparked much innovation at the state level. Between FY 2001 and FY 2009, the Centers for Medicare and Medicaid Services (CMS) awarded 352 Real Choices Systems Change Grants for Community Living totaling \$284 million to help states transform their systems for delivering LTSS through regulatory, administrative, program, and funding infrastructure change.⁸ Included were grants to states to develop Aging and Disability Resource Centers (ADRCs) where people of all ages, incomes, and disabilities can obtain—through a “single point of entry”—information and referrals for LTSS.

Signed into law, the Deficit Reduction Act of 2005 (DRA) authorized the Money Follows the Person (MFP) demonstration, which provides states with an enhanced federal medical assistance percentage (FMAP) for one year for each individual who meets program eligibility requirements and transitions from an institution to a qualified community setting. Forty-two states and the District of Columbia are currently participating in MFP and the program was extended through 2016 under ACA. The DRA amended Section 1915 of the Social Security Act, adding a new subsection (i) authorizing an optional state plan benefit that enables states to offer HCBS under the Medicaid state plan. In addition, the DRA established the Long-Term Care Partnership Program, which enables consumers to purchase long-term care insurance policies and still qualify for Medicaid under special eligibility rules in the event the policy does not cover all of the consumer’s long-term care.

The Current Economic Climate

The severe recession that began in 2007 officially ended in June 2009, but the recovery has been painstakingly slow and the aftermath continues to batter state budgets.⁹

The American Recovery and Reinvestment Act of 2009 (ARRA) provided a temporary increase of 6.2 percent in states’ Federal Medicaid Assistance Percentage (FMAP) through December 2010.¹⁰ That enhanced FMAP resulted in an estimated \$87 billion in fiscal relief to states in FY 2009 and FY 2010.¹¹ In August 2010, President Obama signed legislation authorizing an extension of the enhanced FMAP through June 2011, but at the reduced rate of 3.2 percent during

News. Retrieved November 17, 2010, at <http://www.kaiserhealthnews.org/Stories/2010/October/21/Georgia-mental-health-settlement.aspx>.

7 Kaiser Family Foundation. StateHealthFacts.org.

8 Real Choice Systems Change. (2010). Baltimore, MD: Centers for Medicare and Medicaid Services. Accessed November 1, 2010, at https://www.cms.gov/CommunityServices/30_RCSC.asp.

9 National Bureau of Economic Research. (2010, September 20). Report from the Business Cycle Dating Committee. Boston, MA: National Bureau of Economic Research. Retrieved on October 25, 2010, from <http://www.nber.org/cycles/sept2010.html>

10 American Recovery and Reinvestment Act of 2009.

11 Smith, V., Gifford, K., Ellis, E., Rudowitz, R., & Synder, L. (2010, September). Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends. Washington, D.C.: Kaiser Family Foundation.

the first quarter of Calendar Year (CY) 2011 and 1.2 percent during the second quarter.¹² The enhanced match has been a significant help to states struggling to continue to provide health care coverage to needy populations as state revenue plummeted and Medicaid enrollment grew by 6 percent in FY 2009 and an estimated 8.3 percent in FY 2010.¹³

However, the maintenance of effort requirement under ARRA—which prohibits states from restricting Medicaid eligibility standards and procedures beyond those rules in effect as of July 1, 2008—eliminated one tool that states had used frequently in the past to manage spiraling Medicaid costs. The maintenance of effort requirement also placed restrictions on Medicaid LTSS eligibility and service delivery, leaving states unable to:

- increase stringency in institutional level of care determinations;
- adjust waiver cost neutrality determinations from aggregate to individual level calculations; and
- reduce waiver capacity for filled or unoccupied slots.

Those restrictions, at a time when budgets were continuing to decline, left states with few options for altering their programs to close budget shortfalls. As a result, states have turned to other tools such as provider rate cuts and benefit restrictions. In FY 2010, 39 states reported implementing a provider rate cut or rate freeze and 20 states reported benefit restrictions.¹⁴ States report a commitment to maintaining current service levels as well as expanding community-based services, but acknowledge that the current economic climate and the phase-down of the enhanced FMAP may limit their ability to do so.¹⁵

LTSS: Challenges in Expanding and Rebalancing

While states have made progress in rebalancing LTSS from an emphasis on institutional care to increased utilization of community-based LTSS, much remains to be done if they are to realize the promise of the Olmstead decision and to advance meaningful and individualized options that reflect consumer choice.

Medicaid spending on institutional and community-based LTSS for the 3 million individuals across the United States who rely on these services totaled \$114 billion in FY 2009. Thirty-two states reported that Medicaid expenditures for community-based care exceeded 40 percent of total Medicaid expenditures for LTSS. Excluding expenditures for the population with developmental disabilities—where states have made significantly greater progress in rebalancing—spending for community-based services for the elderly population and those with physical disabilities exceeded 40 percent of total LTSS spending in only 11 states.¹⁶

States are in a continual process of rebalancing their systems, and have a variety of waiver, state plan amendment, and programmatic options to expand LTSS. However, they confront a variety of challenges.

Mandatory versus Optional Medicaid Benefits: States continue to be constrained by Medicaid’s “institutional bias.” Nursing home care is an entitlement, which means that all Medicaid beneficiaries who meet a state’s financial and clinical eligibility requirements are entitled to nursing home care. In contrast, personal care is an optional state plan benefit and states may choose to offer 1915(c) HCBS waivers. In times of budgetary stress, states may reduce eligibility or limit

12 Public Law 111-226, August 10, 2010.

13 National Governors Association and National Association of State Budget Officers. (2010, June). *The Fiscal Survey of States*. Washington, D.C.: National Association of State Budget Officers.

14 Smith, V., Gifford, K., Ellis, E., Rudowitz, R., & Synder, L. (2010, September). *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends*. Washington, D.C.: Kaiser Family Foundation.

15 AARP, Health Management Associates, and NASUAD. (2010, September 27). *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports. Preliminary Findings of a 50-State Survey*.

16 Thomson Reuters. (2010, August 17) Medicaid long-term care expenditures FY 2009. Retrieved from <http://hcbs.org/moreInfo.php/nb/doc/3325/>.

services provided under waivers or the personal care benefit, but not for nursing home care. Medicaid’s “institutional bias” is a serious impediment to rebalancing.

Benefit Reductions: Because of maintenance of effort requirements, states have resorted to reducing or eliminating optional benefits in an effort to close budget shortfalls. In 2010, the most frequently cited benefit restriction was for optional state plan personal care services. States report a commitment to maintaining current service levels as well as expanding community-based services, but acknowledge that the current economic climate and the phase-down of the enhanced FMAP is limiting their ability to do so.¹⁷

Administrative and Workforce Shortages: Because of continued budgetary shortfalls, states have also been forced to cut their administrative operations and staffing. States report that talented workers are leaving, critical positions are going unfilled, and furloughs do not necessarily translate into savings.¹⁸ The declining state workforce, occurring at the same time that demand for services is rising, makes it increasingly difficult for states not only to manage current Medicaid programs but to innovate, such as applying for waivers and grants for new initiatives and pursuing new opportunities available under the Affordable Care Act. Additionally, cutbacks in state workers has affected staffing in state-operated long-term care facilities and the quality of care provided by these institutions.

Investment Needed for Expansion of HCBS: Implementing a new HCBS waiver program or other community-based services requires significant investment in the short-term. A recent study found that expanding Medicaid HCBS typically results in a short-term increase in spending, followed by a decline in institutional spending and eventual long-term cost savings. Also, states with limited non-institutional services experienced greater spending growth than states with more expansive non-institutional LTSS. Moreover, states will achieve savings in Medicaid institutional costs only if the number of nursing home residents is reduced over time.¹⁹ That often means reducing the number of licensed nursing home beds.

Complicated Waiver Processes: The primary vehicle states used to deliver Medicaid community-based LTSS is the HCBS waiver authorized under Section 1915(c) of the Social Security Act. Given the budgetary climate, the number of states developing new HCBS waivers or expanding the number of people served by existing waivers declined in FY 2010 and FY 2011. In addition, applying for waivers involves a significant investment in resources to develop the waiver program and secure CMS approval. States often find this to be a complex and time-consuming process, particularly when resources are limited.

Additionally, many states have multiple waiver programs for the same populations, resulting in administrative duplication and complexity. Some states are consolidating several waivers into a single waiver to provide beneficiaries with a wider array of service offerings and to reduce administrative costs. A new CMS regulation allows states to include different populations in a single waiver, another opportunity for states to reduce administrative burdens and devise waiver programs that offer a wider array of services and are more responsive to client needs.²⁰

HCBS as a State Plan Benefit: States can provide certain HCBS services through Medicaid state plan amendments such as the 1915(i) authorized under the ACA, which allows states to target individuals with special conditions. However,

17 AARP, Health Management Associates, and NASUAD. (2010, September 27). Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports. Preliminary Findings of a 50-State Survey.

18 Center for State and Local Government Excellence. (2010, January). The Great Recession and the State and Local Government Workforce. Washington, D.C.: Center for State and Local Government Excellence. Retrieved on October 25, 2010, from http://www.slge.org/index.asp?Type=B_BASIC&SEC=%7B22748FDE-C3B8-4E10-83D0-959386E5C1A4%7D&DE=%7BA2C3B182-E31F-446B-B1CB-19D1CDD5BAEB%7D.

19 Kaye, S.H., LaPlante, M.P., & Harrington, C. (2009). Do Noninstitutional Long-Term care Services Reduce Medicaid Spending? Health Affairs, vol. 28, no. 1.

20 Federal Register. (2011, April 15). Medicaid Program; Home and Community-Based Services (HCBS) Waivers. Vol. 76, No. 73.

once a state plan amendment is approved, the new service becomes an entitlement and states have limited control over *the number of people to enroll in the programs*, which can become problematic when budgets are limited and states are seeking ways to reduce costs.

Maximizing Use of Information Technology (IT): An effective LTSS delivery system will require integrated data systems so that electronic health and care management records can be shared across care settings and providers. IT will improve care coordination, facilitate telemedicine, and provide a means for effectively monitoring the quality of care provided by direct service workers. A lack of state funding and federal incentives to stimulate IT development is a major barrier to systems development and integration. In addition, because the LTSS system is comprised of a large number of small agencies and independent providers, client records are widely dispersed and many providers do not have the resources to develop, implement, and maintain IT systems.

Moving HCBS Programs to Scale: Many HCBS programs remain in a pilot or demonstration phase, serving limited populations and geographic regions despite successful implementation and demand for services. The availability of LTSS providers and robust provider networks, particularly in rural and frontier areas, is a major concern for states looking to expand their HCBS programs.

Despite Challenges, States Lead LTSS Innovation

In striving to overcome the challenges presented by the current environment, states have become the driver of innovation in LTSS by creatively using federal authority and demonstration projects. States have designed waiver programs to meet the needs of a variety of populations, including elderly individuals, children and adults with physical and developmental disabilities, and individuals with conditions such as mental illness, HIV/AIDS, and traumatic brain injury. Many states offer participants the opportunity to self-direct services. That can range from giving participants the authority to hire, supervise, and terminate personal attendants to providing participants with an individual budget and the opportunity to select their own services from an approved list provided by the state. Care coordination is a feature of many waivers in an effort to ensure that LTSS services are coordinated with acute care and behavioral health services.

States provide home health (a mandatory state plan benefit) and have the option to provide personal care as part of their LTSS benefit package. In 2007, 813,848 individuals received home health benefits at a total cost of \$4.9 billion. Thirty-one states and the District of Columbia provided personal care services to almost 826,251 individuals at a cost of \$9.5 billion.²¹

With more than \$35 million from the U.S. Administration on Aging, 28 states have launched Community Living Programs to divert individuals from nursing homes and delay or avert spend-down to Medicaid eligibility. Five states have taken advantage of Section 1915(i) under the DRA to offer LTSS as an optional state plan benefit, including Wisconsin which intends to provide LTSS to individuals with serious and persistent mental illness.

Seven states—**Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, and Texas**—operate managed long-term care programs in which the state contracts with health plans or managed care organizations (MCOs) to provide LTSS to Medicaid beneficiaries for a per-member, per-month capitation payment. Reflecting individual states' goals and priorities, the programs vary in scope and scale and operate under different waiver authorities. Some programs operate statewide whereas others are limited to certain regions of the state. Some include LTSS only, whereas others include primary and acute care in addition to LTSS. For dual eligibles—those individuals who are eligible for both Medicare and Medicaid—several programs coordinate services across Medicare and Medicaid using Medicare Advantage Special Needs Plans (SNPs).

21 Kaiser Family Foundation. StateHealthFacts.org.

Global budgeting for LTSS is a strategy some states have used to provide more flexibility in spending for LTSS. By pooling available funding for institutional care and home and community-based services rather than subjecting these to separate budget categories, states have greater freedom to manage costs across budget categories while working within overall spending limits. By giving a single administrative authority responsibility for the global budget, states can better control caseloads and costs and enable “money to follow the person” across agencies and programs.

Vermont and Rhode Island have turned to five-year Section 1115 demonstration waivers that place a ceiling on federal participation in the state’s Medicaid program. Those states were seeking greater administrative flexibility in the provision of Medicaid LTSS and strategies to contain costs. Vermont is now proposing that the state function as the entity that manages care for dual eligibles. That would include combining the Medicare and Medicaid funding streams and a financing arrangement that would enable the state and the federal government to share any savings.²²

North Carolina is now enrolling dual eligibles in Community Care of North Carolina (CCNC) in a “shared savings” demonstration under a Section 646 waiver under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CCNC, operating since 1998, provides Medicaid beneficiaries with a medical home, care coordination, and disease management through local non-profit provider networks. Any cost savings from serving dual eligibles will be shared by the state and the federal government.

States are demonstrating leadership in expanding the availability of LTSS in other ways, such as the development of universal assessment tools to streamline the assessment process and more targeted, cost-effective plans for care. Recognizing the importance of a competent workforce for personal assistance services and attendant care, states are experimenting with new strategies for expanding the pool of direct care workers, such as training programs and public authorities serving as employers of record.

These examples of state innovation offer informative lessons and promising models as states consider new strategies to strengthen and expand their LTSS systems. With passage of the ACA, many new opportunities are now available to states and new initiatives should be carefully evaluated before implementation.

Continuing the Commitment to Rebalancing

Below are some additional considerations for states as they work to further rebalance their LTSS systems:

Consumer Direction: LTSS programs that enable individuals and/or their guardians to choose from among a variety of services and providers and manage a service budget hold promise for better accommodating individual needs and preferences while containing program costs. Allowing beneficiaries to select their services can promote greater independence and minimize the need for personal/attendant care, particularly when beneficiaries have access to assistive technologies, emergency response systems, and adult day care.

Nursing Home Diversion: Programs that emphasize community-based services and supports aimed at preventing vulnerable individuals from entering a nursing home will be increasingly important, both for Medicaid beneficiaries and low-income people who are likely to become Medicaid-eligible if they enter a nursing home. Many states have programs such as those that are an integral component of their continuum of services. Those programs are typically financed with state funds only.

²² Gore, S., Lind, A., Somers, S.A. (2010, November). Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles. New Jersey: Center for Health Care Strategies.

Community Behavioral Health: States report many individuals with mental health conditions who reside in institutions and would like to transition to the community but have no place to go. Community-based behavioral health supports are severely lacking, both for Medicaid beneficiaries and others. It will be up to states to design and test new innovations for this population.

Direct Care Workforce: An adequate and competent direct care workforce is necessary if states are to succeed in further rebalancing. Consumer-directed care models that enable Medicaid participants to hire the workers they select—including friends and relatives—is a promising model for expanding the direct care workforce. States can encourage that movement by providing training and supports to direct care workers and their employers. However, some states are concerned that those workers may displace informal caregivers, whose contributions were valued at \$375 billion in 2007.²³

Information Technology: This will be key to achieving efficiencies in service delivery. Automating and linking assessments, plans of care and case records through state health information exchanges, with Medicaid administrative data, Minimum Data Set (MDS) data for nursing home residents, and other datasets will enable states to maintain a single record on each client and help providers “follow the person” as clients navigate from one care setting to the next. With automated and linked data, states can also produce reliable metrics for monitoring program performance and client outcomes.

Global Budgeting: Pooling available funding for institutional and community-based care and placing financing and program decisions under the same administrative authority will enable “money to follow the person” from one care setting to the next. In recent years, many states have divided responsibility for LTSS among several different agencies—some with budget responsibility and others with program or service responsibility. That often creates an unhealthy tension across agencies and works against fiscally responsible program planning and administration.

Charting the Future: New Opportunities in the Affordable Care Act

The Affordable Care Act offers a number of opportunities and financial incentives for states seeking to expand their LTSS systems. Many of those opportunities can be leveraged to work together and to build on existing initiatives. The result could be a strengthened infrastructure for service provision and an LTSS system that can better meet the needs of Medicaid beneficiaries.

However, states will face many competing priorities in the immediate future as budgets continue to be constrained, ACA “maintenance of effort” requirements limit flexibility, and states focus on implementing health exchanges by 2014 as required under the ACA. Through careful planning within the state agency structure, as well as smart use of technical assistance offered by the federal government and other organizations, LTSS system transformation can still remain a priority.

Promoting Integrated Care for Dual Eligibles

Integrated care programs for dual eligibles hold much promise, but barriers to coordinating Medicare and Medicaid benefits and structuring incentives to minimize cost-shifting across the two programs have been an issue. For example, states need to access Medicare claims data in order to analyze and monitor service utilization and costs for dual eligibles. Medicare “freedom of choice” prohibits states from requiring dual eligibles to enroll with the same health plan for their Medicare and Medicaid benefits. Consequently, in states with integrated programs, typically only a small percentage of dually eligible participants are enrolled with a single health plan.

23 Houser, A. & Gibson, M.J. (2008). Valuing the invaluable: The economic value of family caregiving, 2008 update. (Insight on the Issues 13). Washington, D.C.: AARP Public Policy Institute.

The Medicare-Medicaid Coordination Office (MMCO) authorized by Title II, Section 2602, of the ACA is now in operation and is addressing many of these barriers. The MMCO is charged with improving the coordination between the federal government and the states to improve access to services for dual eligibles. MMCO intends to:

- Provide states with analytical tools and access to Medicare claims data to evaluate service utilization and costs for duals;
- Allow for three-way contracts among Medicare, Medicaid and qualified Medicare Advantage health plans (Special Needs Plans);
- Identify administrative, regulatory, and legislative policies that would improve the integration of Medicare and Medicaid services; and
- Encourage state innovation through technical assistance and demonstrations.

MMCO is closely aligned with the Center for Medicare and Medicaid Innovation (CMMI) established through Section 3021 of ACA. In April 2010, CMMI announced awards for design contracts to 15 states to develop innovative service delivery and payment models for dual eligibles.²⁴ In July 2011, CMS announced two new financial alignment models for dual eligibles that CMS seeks to test with states. In October 2011, CMS reported that 37 states and the District of Columbia had expressed interest in these new models.²⁵

ACA authorizes five-year approval or renewal periods for certain Medicaid waivers serving dual eligibles (Section 2601). This includes demonstration programs under section 1115 of the Social Security Act, which are normally approved for an initial five-year period with extensions of three years. Also included are Section 1915(b) waivers, which are on a two-year approval and renewal cycle, and Section 1915(c) HCBS waivers, which receive initial approval for three years, followed by five-year renewal periods.²⁶ Until now, states with concurrent 1915(b)(c) waivers for integrated care programs for dual eligibles were forced to contend with waivers for the same program that were on different renewal cycles. Concurrent five-year approval and renewal periods will greatly simplify waiver administration for states.

Section 3205 of ACA extends the authority for Medicare Advantage SNPs to 2014. ACA also allows the U.S. Department of Health and Human Services (DHHS) to apply a frailty payment adjustment for SNPs that serve dual eligibles in fully integrated programs with capitated contracts for Medicaid benefits. That provision provides an additional financial incentive for health plans to offer SNPs for dual eligibles.

Money Follows the Person Demonstration

Title II, Section 2403, of ACA extends the Money Follows the Person demonstration until 2016, with appropriations totaling \$2.25 billion for FYs 2012-2016. Thirteen additional states were awarded MFP demonstration grants in February 2011, bringing the total number of states participating in the demonstration to 42 plus the District of Columbia. With financial incentives for IT and infrastructure development and the availability of funding for specialized staff and training, MFP is being positioned by many states as a centerpiece of rebalancing efforts.

State Balancing Incentive Payments Program

The **State Balancing Incentive Payments Program** (Title X, Section 10202), which went into effect October 1, 2011, provides an increased FMAP to states who meet certain rebalancing targets. States spending less than 25 percent of LTSS expenditures for community-based services will receive a 5 percent increase in FMAP and be expected to reach a target of 25 percent of expenditures for community-based services by October 1, 2015. States with 25 percent to 50 percent of

24 State Demonstrations to Integrate Care for Dual Eligible Individuals. (2010, December). The Center for Medicare and Medicaid Innovation. Accessed January 12, 2011, at <http://innovations.cms.gov/opportunities/opportunities.shtml>.

25 Centers for Medicare and Medicaid Services. (2011, July 8). State Medicaid Director Letter #11-008, ACA #18.

26 Centers for Medicare and Medicaid Services. (2010, November 9). State Medicaid Director Letter #10-022, ACA #11.

LTSS expenditures for community-based services will receive a 2 percent increase in FMAP and be required to reach 50 percent of expenditures for community-based services by October 1, 2015. The legislation is silent on sanctions for states who do not meet the rebalancing targets. Participating states will have data collection requirements and must implement a single-point-of-entry system for accessing LTSS, conflict-free case management services, and a core standardized assessment tool. In addition, participating states may not impose stricter eligibility standards than were in place on December 31, 2010. States are advised to study forthcoming guidance for this program carefully to determine whether they would be able to meet what could be very aggressive rebalancing goals.²⁷

New State Plan Options for Community Living

Community First Choice Option: Under Title II, Section 2401, ACA authorizes, effective October 1, 2011, a Medicaid state plan option for community-based attendant services for all Medicaid-eligible individuals with incomes up to 150 percent of FPL and for those with incomes up to 300 percent of FPL who meet nursing facility clinical eligibility criteria. The optional state plan benefit may also include transition services and certain assistive technologies. States adopting the optional state plan benefit will receive a 6 percent increase in FMAP for those services *indefinitely*. A maintenance of effort requirement stipulates that the state's share of Medicaid expenditures for personal care attendant services must remain at the same level or be greater than expenditures during the year prior to implementation of Community First Choice. States must also offer a consumer-directed option, establish an advisory council with a majority of consumer members, meet data collection requirements, and maintain a continuous quality improvement program. As an optional state plan benefit, the service is an entitlement and the state cannot place a ceiling on enrollment or offer the service other than statewide. As a result, states that do not currently offer personal assistance in 1915(c) waivers or as an optional state plan benefit will likely find a new entitlement such as this to be exceedingly expensive. However, states that already offer generous personal assistance benefits may be able to take advantage of the Community First Choice Option to implement a measured benefit expansion at an increased FMAP in perpetuity.

1915(i) State Plan Amendment: The Deficit Reduction Act amended Section 1915 of the Social Security Act by adding subsection (i) to enable states to offer home and community-based services as a state plan benefit. However, only five states adopted the 1915(i) state plan benefit, so Title II, Section 2402, of the ACA amends it in an attempt to encourage more states to consider this option. States can now target benefits to individuals with selected conditions. For example, states could target Medicaid beneficiaries with mental health conditions residing in institutions for mental diseases (IMDs). However, states must now offer the benefit statewide and there can be no ceiling on the number of individuals receiving the benefit. Given that programs are not yet ready for evaluation, it remains to be seen if the 1915(i) is an effective means for providing specialized community-based supports to populations who might otherwise find it difficult to transition to the community.

Health Homes: Title II, Section 2703, of ACA permits states to provide a "health home" to Medicaid beneficiaries with at least two chronic conditions under a new state plan option. The health home provider will be responsible for coordinating all of the individual's care. That new option became available to states on January 1, 2012. The FMAP for those services will be 90 percent for the first two years that the state plan amendment is in effect. Recognizing that a new service such as this will require planning and development of a new payment methodology, the federal government is encouraging requests from states to spend up to \$500,000 of Title XIX funding for planning activities.²⁸

Other Opportunities in LTSS

Title II, Section 2405, of the ACA authorizes \$10 million in each of FYs 2010-2014 to enable states to continue to develop their network of Aging and Disability Resource Centers. Title VI, Section 6114, authorizes demonstration projects to promote

²⁷ See Centers for Medicare and Medicaid Services. (2011, September 12). State Medicaid Director Letter #11-010, ACA #20. Also see accompanying application for more details on program requirements.

²⁸ Centers for Medicare and Medicaid Services. (2010, November 16). State Medicaid Director Letter #10-024: Health Homes for Enrollees with Chronic Conditions.

culture change and IT development in nursing homes. While that funding will not flow directly to states, it will contribute to infrastructure development and improving the quality of care in nursing homes. Similarly, grants to institutions of higher education for tuition assistance for direct care workers (Title V, Section 5302) will help to build the future LTSS workforce.

Final Thoughts

Most states will continue to confront severe budget deficits over the next few years. Nevertheless, states voice an unwavering commitment to rebalancing their LTSS systems and ensuring that services are available to all who need them. Agency staffing shortages, a dearth of mental health and other services, and an exploding aging population are just a few of the challenges states face. States are further constrained by the Medicaid eligibility “maintenance of effort” requirements in the ACA, which severely limit the tools states have to innovate and bend the Medicaid cost curve. States must find ways to allocate staff time and resources to LTSS transformation at the same time they are implementing major health reform required by the ACA, ranging from Medicaid expansions to health insurance exchanges. Because many of the LTSS provisions in the ACA are optional for states, LTSS reform risks being put aside while states tackle other federally mandated priorities.

LTSS provisions in the ACA offer an unprecedented opportunity to leverage the states’ efforts, building on existing initiatives, experimenting with new designs, and creating new infrastructure. The ACA offers enhanced FMAP as part of the MFP demonstration, the Community First Choice Option, the State Balancing Incentive Payments Program, and the option to provide health homes to Medicaid beneficiaries with chronic conditions. Grant funding is available for the development of ADRCs and integrated care innovations for dual eligibles. Opportunities abound for creative financing and program design with transformative potential.

Integrating Medicare and Medicaid services for dual eligibles holds great promise for reducing LTSS costs while providing improved services to dual eligibles, particularly when the Medicare and Medicaid funding streams are combined. The new MMCO at CMS is committed to this purpose and states may want to consider how to take advantage of the funding opportunities and technical assistance that will be available through this new office.

States should proceed cautiously with the new options for state plan amendments. Many states that offer the personal care services optional state plan benefit have seen large increases in expenditures over the past decade. State plan amendments create new entitlements and states have limited control over utilization of these services.

Waivers have been and will continue to be very effective tools for providing HCBS. However, many states find they are administering multiple waivers serving the same populations. Some states have consolidated several waivers into a single waiver in order to provide beneficiaries with a wider array of service offerings while reducing administrative complexity. The new five-year renewal cycle for waivers targeting dual eligibles will also help reduce the administrative burden for states.

States would be wise to address recurring themes found in the ACA as they consider LTSS system reform. The legislation repeatedly calls for consumer direction, universal assessment tools, electronic records, and one-stop, single-point-of-entry systems for accessing LTSS, often as a requirement for participation in certain programs authorized by the ACA. Universal assessment tools will be particularly important in helping states to more precisely identify needs and control excessive service utilization. States with such tools have found them to be very effective for designing cost-effective plans of care.

Rebalancing is not easy. System transformation occurs incrementally and states should expect bumps along the way. However, new opportunities in the ACA will enable states to continue to work towards rebalancing their LTSS systems.