MEDICAID LTSS

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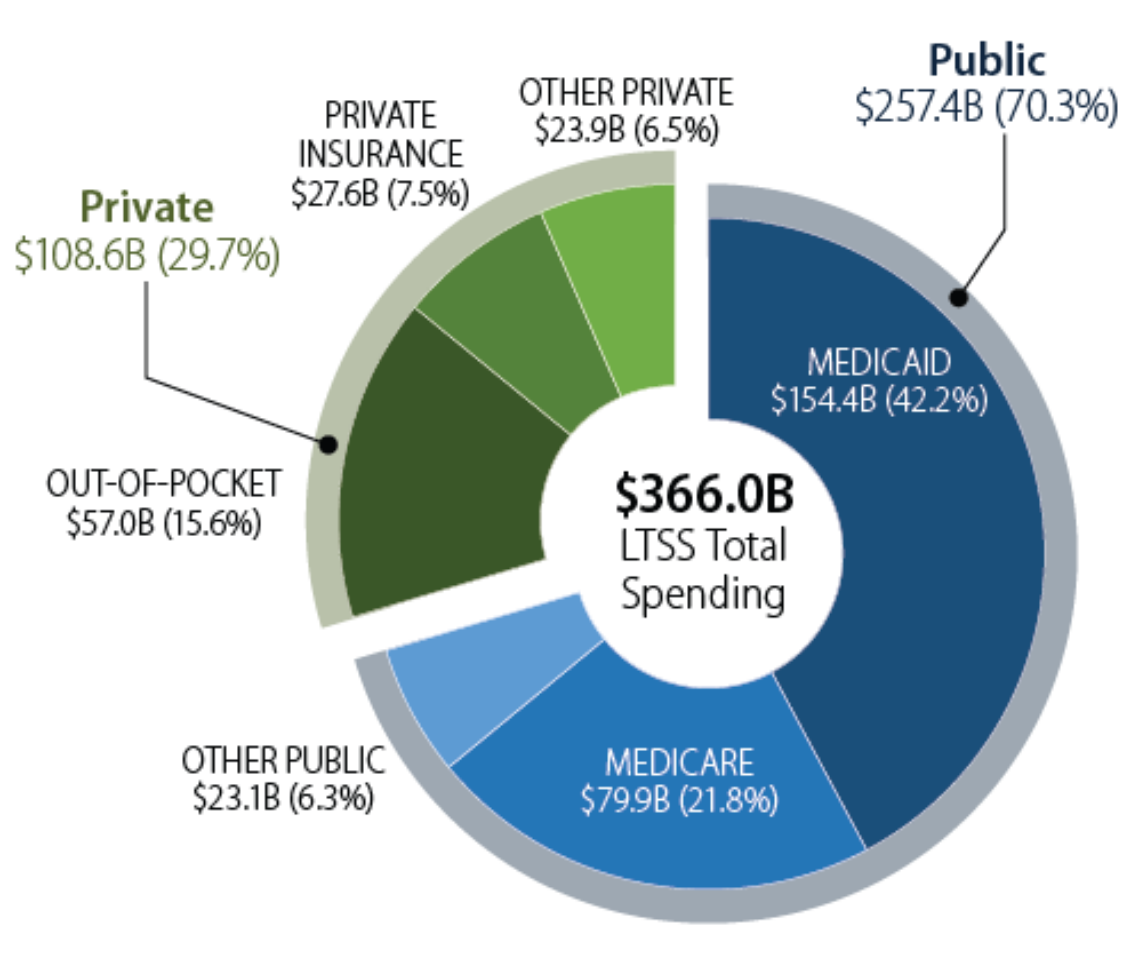
AGENDA

- Medicaid's Role in LTSS
- Institutional and Home and Community-based benefits
- *Olmstead v. LC* and the Evolution of Home and Community-Based Services
- Authorities: State Plan Amendments, Waivers and Demonstrations
- Challenges and Opportunities

Who pays for Long-Term Care?

LTSS by Payor, 2016



Source: Who pays for Long Term Services and Supports, Congressional Research Services, August 22, 2018, accessed on November 2, 2020, https://fas.org/sgp/crs/misc/IF10343.pdf

Medicaid LTSS includes both Institutional and Home and Community-Based Services

- Institutional Services are mandatory
- HCBS Services are optional.

Institutional Services

*Inpatient Hospital
*Nursing Facility

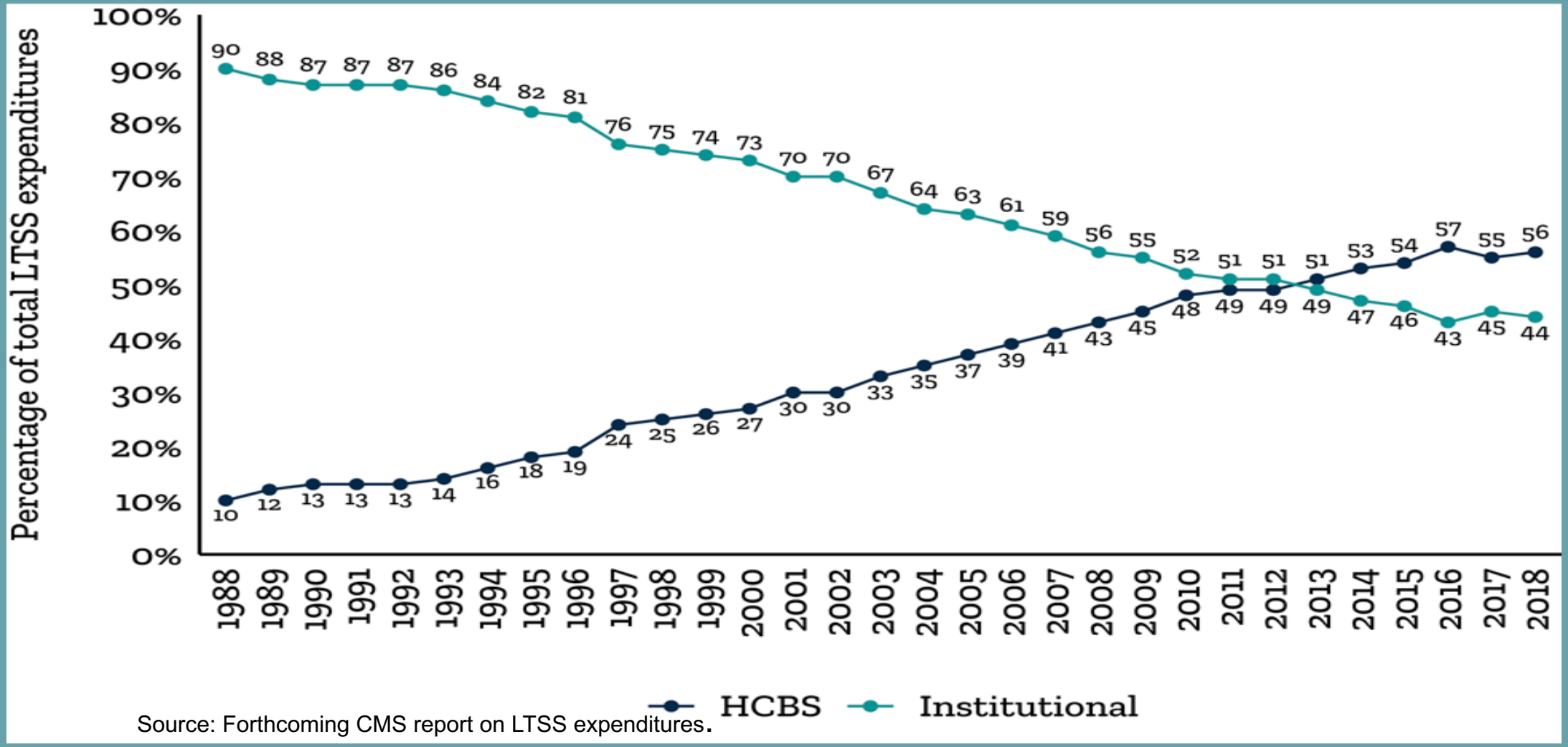
HCBS Services

*Personal Care Assistance *Case Management *Home Modifications *Personal Emergency Response Systems *Family Support & Training* Respite Care * Assisted Living *Home Delivered or Congregate Care Meals *Home Health Services *Home Safety Assessments * Supported and Shared Living * Supported Employment * Pre-vocational Training *Assistive Devices and Supplies *Transition Assistance *Consumer-directed Care * Homemaker and Chore Service *Crisis services *Transportation *Behavioral Supports. *Diet and Nutrition Services

The Impact of the ADA and *Olmstead V. LC, 527 U.S. 581 (1999)*

- 1990 – Americans with Disabilities Act (ADA), Title II, prohibits public entities from discriminating against individuals with disabilities in the provision of public services.
- "Integration Regulation" – Requires public entities to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities. (28 CFR 35.130(d))
- Public entities further must make "reasonable modifications" to avoid discrimination based upon disability.
- In *Olmstead*, affirmed that unjustified isolation is properly regarded as discrimination based upon disability. States *must* place persons with disabilities in community settings rather in in institutions:
  - *When the States treating professionals have determined that community placement if appropriate,*
  - *The transfer is not opposed by the affected individual, and*
  - *The placement can be reasonably accommodated, taking into account the resources available to State and the needs of others with mental disabilities.*

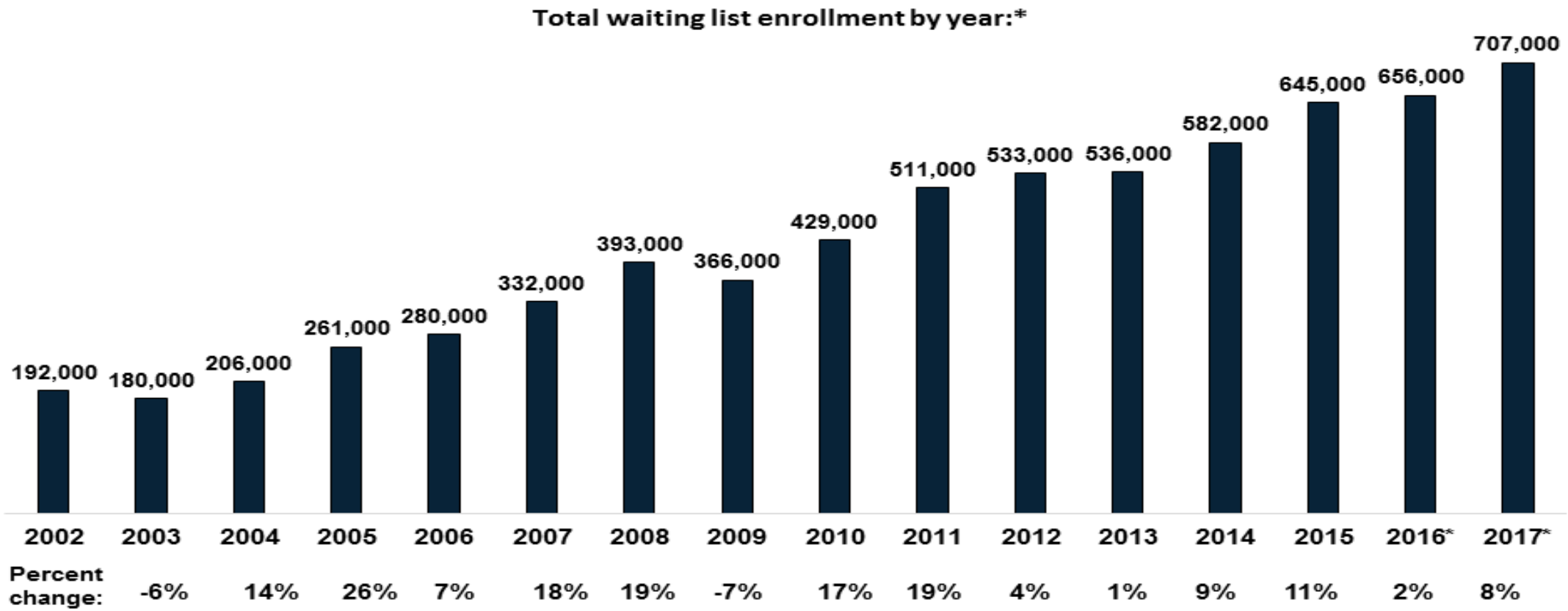
Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, FY 1988 to 2018



Source: Forthcoming CMS report on LTSS expenditures.

Figure 1

Medicaid HCBS waiver waiting list enrollment, 2002-2017.



NOTES: Percent change is calculated using unrounded totals. *Beginning in 2016, totals include Section 1916 (c) and Section 1115 HCBS waiver waiting lists except that CA and NY did not report enrollment for Section 1115 waiting lists; prior years include only Section 1915 (c) waiver waiting lists.
SOURCE: Kaiser Family Foundation Medicaid FY 2002-2017 HCBS program surveys.

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Key Concepts in Understanding State Authority to "Draw Down" Federal Medicaid Dollars to Pay for Services that Support HCBS Services

- **Medicaid State Plan** – Operational Agreement between Federal Government and State that gives State authority to draw down federal match for approved services.
- **Waivers** – Allows Federal Government to exempt States from specific Medicaid statutory requirements
- **Federal Financial Participation or FFP** - The federal share of Medicaid spending.
- **Federal Medical Assistance Percentage or FMAP** – The formula used to determine the amount of a State's FFP. It is based upon the average per capital income for each State relative to the national average.
  - *FMAP cannot be lower the 50%.*
  - *Some programs and services are eligible for enhanced FMAP rates.*
  - *FMAP for Administrative activities is capped at 50%.*

For every State dollar spent on an allowable service, the federal government will match it at the State's FMAP rate.

Medicaid Benefits and Programs that Support Community-based Services

State plan benefits that include HCBS	HCBS authorities	Research and demonstration programs	Integrated care programs	Managed long term services and supports (MLTSS)	Medicaid administrative activities
• Home health • Personal care services • Case management and targeted case management • Section 1945 Health Home	• Section 1915(c) • Section 1915(i) • Section 1915(j) self-directed personal care services • Section 1915(k) Community First Choice	• Section 1115 demonstrations • Money Follows the Person (MFP) demonstration	• Programs for All-Inclusive Care for the Elderly (PACE) • Accountable care organizations (ACOs) • Integrated care for people dually eligible for Medicare and Medicaid	• Including those authorized under Section 1915(a) or 1915(b) waivers	• Partnership development • Data and information technology

CMS LTSS Toolkit: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

1915(c) Home and Community Based Services Waiver

Who can be served?

- Individuals who require an institutional level of care (hospital, nursing facility or ICF/ID).
- Are a member of a target group that is included in the waiver. (States may include multiple target groups in a single waiver).
- Meet applicable financial eligibility criteria.
- Require one or more waiver services in order function in the community, and
- Exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care
- State must specify the unduplicated number of individuals to be served.

1915(c) Home and Community Based Services Waiver

What Services can be Offered?

- State may offer services enumerated in the statute or propose other services that assist individuals to remain in the community – there are no required services.
- Waiver services compliment State Plan Services; a waiver participant must have full access to State Plan Services.
- States can offer extended State Plan Services that exceed the limits that apply under a State Plan.
- There is no limit to the number of services that a state may offer in a waiver.
- States may not claim Federal Match (FFP) for Room and Board

1915(c) HCBS Waivers Assurances

States must assure CMS that HCBS Waiver programs will:

- Be cost neutral (cannot cost the federal government more than providing services in an institution).
- Protect the health and safety of individuals in the program.
- Provide adequate and reasonable provider standards to meet the needs of individuals served in the waiver.
- Ensure that services follow an individualized and person-center plan of care.
- Develop and implement a quality improvement strategy.
- Comply with HCBS settings rule requirements.

A Note on Cost Neutrality

- States must ensure that the average per capita expenditure under the waiver does not exceed 100 percent of the average per capital expenditures that would have been made had the waiver not been granted.
- Cost neutrality formula looks at total Medicaid costs, not just waiver costs.

  Factor D – Per Capita Medicaid Cost for HCBS Services

  Factor D' – Per Capita Medicaid cost for all other services provided to Waiver Participants

  Factor G – Per capital Medicaid cost for NF or ICF/ID care

  Factor G'- Per Capita Medicaid Costs for all Services other than those in G
- Formula: D+D' Compared to G+G'

Section 1115 Research & Demonstration Waivers

- Give HHS Secretary broad authority to approve experimental, pilot or demonstration projects to promote the objectives of the Medicaid program.
- Demonstrations must be “cost neutral” to the Federal government meaning Federal Medicaid expenditures will not be more than Federal spending without the demonstration over the life of the project.
- Generally approved for an initial five-year period and can be extended an additional 3-5 years.
- Evaluation/Reporting requirements.
- Examples: (1) “Cash and Counseling” in 1990(S), lead to inclusion of Participant-Directed Services in 1915(c) Waivers which led to DRA, Section 1915(i), 1915(j) and later 1915(k).
    - (2) Managed Care
    - (3) Comprehensive SUD Services
    - (4) Services to individuals not yet eligible for Medicaid LTSS
    - (5) Pre-ACA – Services to Childless adults
    - (6) Financial Alignment

1915(i) HCBS State Plan Option

- Does not require cost neutrality or an institutional level of care (LOC) – Eligibility based upon needs-based criteria ascertained through independent, individualized assessment.
- Targets one or more specific populations defined by age, diagnosis or Medicaid Eligibility Group.
- Eligibility: Individuals with Income up to 150% FPL (no resource test) or may include individuals with income up to 300% SSI but must be eligible for existing 1915(c) or demonstration.
- Can waive comparability, but not statewideness.
- Enrollment CAPS and Waiting lists are prohibited.
- Allows use of self-direction and presumptive payment.
- State must have and implement an HCBS quality improvement strategy.
- Examples of Services offered: Transitional Case Management Services, Assisted Living, Adult Day Health, Behavioral Supports, etc.

1915(i) Benefits and Challenges

Benefits	Challenges
Can fill gaps in Medicaid coverage for targeted populations including people with serious mental illness and/or SUD, people in transition from criminal justice system, children with special conditions such as autism	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
Can provide coverage for specific services: adult day health, self-direction, housing supports	For non-institutional LOC, income limit of 150% FPL adds administrative complexity and limits coverage (especially for children or working adults)
Allows state to tighten criteria for institutional care without tightening access to HCBS	Cannot phase-in or limit geographic reach due to requirement to implement statewide
	Viewed as administratively burdensome

1915(j) Self Directed Personal Care Attendant Services State Plan Option

- Permits Self-Direction for PCA services. At state option,
  - *Legally responsible Relatives (spouses/parents) may provide care and be paid.*
  - *Allows participants to manage a cash disbursement and/or purchase goods, services and supplies to support community living.*
  - *Use a discretionary amount of the budget to purchase items not otherwise listed in the budget.*
- State may limit geographic area and cap the number of people who can enroll.
- Can include people already enrolled in 1915(c).

1915(k) Community First Choice State Plan Option

- Allows State to establish Personal Care Attendant or Participant Directed Care Program through State Plan Amendment for individuals with institutional LOC.
- State may provide transitional services to help individuals move from institutions to the community and services that increase independence including assistive technologies, medical supplies/equipment and home modifications.
- Provide 6% INCREASE in FMAP for services provided.
- Enrollment caps/waiting lists prohibited.
- Must be offered statewide, benefits must be comparable for all and participants must have freedom of choice (cannot target specific populations) .
- Can limit amount duration and scope provided limits are sufficient to achieve program purpose.
- Eligible individuals include individuals eligible for NF Services under the State plan or, if not in such an eligibility group, have income at or below 150% of FPL.
- Maintenance of effort (MOE) requirement for first 12 months.
- Mandatory data collection and reporting, quality assurance system and development and implementation Council.

1915(k) Benefits and Challenges

Benefits	Challenges
Increased FMAP	Increased FMAP not sufficient to cover new costs association with implementation, program expenditures and evaluation.
Allows states to consolidate programs and standardize eligibility and needs assessments	Does not eliminate need to maintain multiple HCBS programs
	Complex eligibility requirements
	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
	Viewed as administratively burdensome

HCBS Program Design Considerations

- First, identify your goals and objectives.
- Second, identify the needs of the target population – claims analysis, historical spending, key informant interviews, stakeholder input, research into other state and payor practices.
- Third, identify the key design features that will help attain the goals and objectives.
- Design programs around those identified goals and objectives.
- Then, look to the authority that best supports what you hope to achieve.
- There is no right answer and there always will be trade-offs.

HCBS Final Rule
January 16, 2014

- Applies to 1915(C) waivers and 1915(I) AND 1915(K) State Plan Options
- MLTSS/1115 Waiver States (i.e. Arizona) however, also have to comply.
- Designed to promote full access to benefits of community living in the most integrated setting appropriate.
- Mandates conflict-free assessments and case management services.
- Mandates a person-centered planning process and plan for services.
- Establishes mandatory requirements that define an HCBS setting.

HCBS Settings Rule

- General requirements focus on individual choice, autonomy and integration into the broader community.
- Additional requirements for Provider controlled settings
- Settings that are not HCBS include: Nursing Homes, IMDs, ICF/IDs and Hospitals
- Settings that are presumed not to be HCBS and subject to CMS heightened scrutiny review include:

  -Settings in a publicly or privately-owned facility providing inpatient treatment

  -Settings on grounds of, or adjacent to, a public institution

  -Settings with the effect of isolating individuals from the broader community of non-Medicaid individuals
- Settings that do not meet HCBS settings rule standards are not eligible for Medicaid payments.

HCBS Settings Rule

- STATE COMPLIANCE DEADLINE - For programs in existence on March 17, 2014 states had until March 17, 2019 to submit and receive approval of statewide transition plans. States must then submit settings subject to heightened scrutiny. Final Compliance has been extended one year to March 17, 2023 due to COVID.
- HEIGHTENED SCRUTINY DEADLINE - Whether a setting subject to heightened scrutiny meets HCBS standards is determined by CMS based upon information presented by the state. Information must be submitted by October 31, 2021.

Flexibilities Granted to States to Respond to COVID 19

- 1915(c) Waiver Appendix K amendments: Emergency Preparedness and response and COVID 19 Addendum
- Demonstration opportunity under Section 1115(a) of the Social Security Act
- Medicaid State Plan Disaster Relief State Plan Amendment (SPA) under 1915(i) and 1915(k) benefits;
- Section 1135 Waiver

COVID 19 Flexibilities Granted

- Modifications to services (i.e. add home delivered meals, assistive technology, allow telehealth, etc.)
- Modification to provider qualifications and/or enrollment process (i.e., allow other practitioners, payments to family etc.)
- Changes to eligibility and recertification to eliminate signatures and in-person requirements or delay/extend dates (i.e. for LOC determinations or recertification, etc.)
- Provide for Provider retainer payments and increase or modify payments
- Modify person-center planning
- Allow HCBS in institutional settings
- Waive settings and conflict of interest requirements or timelines for compliance

Workforce Issues

- As the baby boom ages and the elderly population grows, more individuals will be called upon to provide unpaid/informal care. Today, informal caregivers provide an estimated 75% of all long-term care to elderly friends and family.
- Demand for informal care givers and paid home health aides and personal care aides will continue to increase.
- According to DOL/BLS, Demand for home health and personal care aides is projected to grow 41% from 2016 to 2026.*
- Yet, number of direct care workers is projected to increase by only 20%.
- COVID 19 has exacerbated the direct care workforce shortage.

Source: Bureau of Labor Statistics, US Department of Labor, Occupational Outlook Handbook, Home Health Aides and Personal Care Aides, accessed at https://www.bls.gov/ooh/healthcare/home-health-aides-and personal-care-aides.htm, visited on July 30, 2018.

Better Medicare

- BiPartisan Budget Act (2018) and CMS regulations (April 16, 2019) are promoting increased integration between Medicare and Medicaid for duals.
- New standards for Medicare and Medicaid for D-SNPS.
  - *All D-SNPS must meet minimum criteria for D-SNPs for 2021:*
    - Be A FIDE SNP, or
    - Provide LTSS and/or behavioral health under a capitated contract with the State or with the MA organization's parent organization and the Medicaid Agency.
    - Adopt and use unified procedures for grievance and appeals.
- Expanded definition of Supplemental Benefits that allows all MA plans (including D-SNPS) to offer benefits that meet members' long-term support needs including in-home assistance, support to family caregivers and adult day health.
- Provides for expanded use of telehealth.

Additional Resources

- CMS LTSS Toolkit: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf
- CMS Waiver List – https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.htmL
- CMS 1915(c) Waiver Technical Guidance – https://www.Medicaid.gov/Medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf
- CMS Technical Assistance Webpage for HCBS – https://www.Medicaid.gov/Medicaid/hcbs/technical-assistance/index.html
- CMS SPA and Waiver Processing page – https://www.Medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html
- NASUAD, Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants, May 2018 - http://nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants_0.pdf
- HSBS Settings: State Responses to COVID 19- https://www.medicaid.gov/medicaid/home-community-based-services/downloads/covid19-state-implications-reactions-innovations.pdf

Questions?