HCBS STRATEGIES, Inc.

Improving Home & Community Based Systems

Implications of the Deficit Reduction Act on Medicaid Funded Long-Term Care

Steven Lutzky, Ph.D.
President
HCBS Strategies, Inc.
www.HCBSstrategies.com
410-366-4227
June 2006

Overview of Medicaid Changes

- Deficit Reduction Act of 2005 Changes to Medicaid
  - Creation of new authority to provide HCBS
  - Grant programs to alter how LTC is delivered by states
  - Efforts to increase HCBS options for children
  - Tightening of Medicaid Eligibility
  - Allowance for Public-Private Partnerships for long-term care insurance
  - Increases in cost sharing authority
  - Curtailing fraud & abuse
  - Katrina relief
- Implications for Medicaid HCBS
  - Access – who and what
  - Quality management
  - Reimbursement

Creation of New HCBS Authorities

- 1915(i) - State Plan Option for Home and Community-Based Services (HCBS)
- 1915(j) – State Plan Option for Self Directed Personal Assistance Services (SD-PAS)
- State Option to Establish Non-Emergency Medical Transportation Program

Section 6086: State Plan Option for HCBS for the Elderly and Disabled - Overview

- State plan option to provide HCBS without states needing to use a waiver process
  - Added as section 1915(i) of the Social Security Act
- Must establish stricter eligibility (level of care) criteria for institutional services/1915(c) HCBS than for 1915(i) HCBS
- States may continue to provide services through their existing waiver programs
- Can cap the number of people to be served
- Can limit areas of the state to be served
- Can maintain waiting lists
- Can include self-directed services
- Effective on January 1, 2007

Comparison of 1915(c) and 1915(i) authorities

	1915(c) HCBS Waiver	1915(i) HCBS State Plan
Similarities		
Services	Same	Same
Number Served	Establish Caps	Can establish caps
Waiting lists	Can establish	Can establish
Budgets	Can use variety of means including setting spending caps for individual or for services	Yes
Can establish budgets for individuals	Yes	Yes
Self-Direction	Can include	Can include
Statewide	Can waive	Can waive
Differences		
Financial Eligibility Maximum	300% SSI (circa 200% FPL)	150% FPL
Functional Eligibility Criteria	NF, ICF -MR or Hospital Level of Care	Needs based criteria and less stringent than criteria for institutions/1915(c) waiver
Federal Oversight	When problems noted, amendments, 3 Year Initial renewal, 5 Year Renewals	When problems noted, amendments

1915 (i) Eligibility Determination Requirements

- Must be needs based criteria
  - No waiver of comparability – can't target by age or population
- Less stringent than criteria for institutions
- Criteria *may* be 2+ ADLs or substantial assistance
- State must have an independent assessment
  - Determine a necessary level of services and supports to be provided
  - Prevent the provision of unnecessary or inappropriate care
  - Establish an individualized care plan

1915(i) Service Coverage

- *"..within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board or such other services requested by the State as the Secretary may approve."*
- Section 1915(c)(4)(B) services
  - case management services
  - homemaker/home health aide services
  - personal care services
  - adult day health services
  - habilitation services
  - respite care
  - day treatment
  - other partial hospitalization services
  - psychosocial rehabilitation services
  - clinic services (whether or not furnished in a facility) for individuals with chronic mental illness

1915(i) Quality Assurance Requirements

- Language in the bill, " The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance"
- Authorizes creation of program performance indicators, client function indicators, and measures of client satisfaction
  - Specifies that **Agency for Healthcare Research and Quality (AHRQ)** will play lead (as opposed to CMS)
  - Requires consultation with consumers, health and social service providers and other knowledgeable professionals
  - Indicators to be used to assess HCBS quality for individuals and the overall system
  - Must make the best practices identified through such assessment and a comparative analyses of the system features of each state publicly available

1915(i) Presumptive Eligibility For Assessment Provision

- Option to provide for presumptive eligibility (not to exceed 60 days)
- Only for those individuals likely to be eligible for HCBS
- Limited to medical assistance for carrying out the independent evaluation and assessment

Points Where Additional Clarity is Needed

- Eligibility Criteria
  - How will CMS define needs-based criteria
- Federal oversight – how will oversight differ from 1915(c)
- Quality
  - How will AHRQ quality indicators relate to the CMS HCBS Quality Framework
  - Uncertain if requirements will be as broad as 1915(c) requirement to assure health and safety
    - If broad, will affect ability of states to offer only a limited package of services

Section 6087: Optional Choice of Self-Directed Personal Assistance Services - Overview

- New state plan option similar to "cash and counseling"
- Must be eligible for personal care services under the State's Medicaid plan or HCBS waiver
- Not allowed if live in property owned, operated, or controlled by a service provider
- Funds can pay for items that increase independence or substitute for human assistance
- Can pay family members, including legally responsible adults (e.g., spouses and parents)
- Can limit the population eligible to receive these services and limit the number of persons
  - Silent about waiting lists
- Effective on January 1, 2007

Operational Requirements in Legislation

- Safeguards to protect health and welfare
- Financial accountability mechanisms
  - Verify services actually provided
- Ability to identify " Individuals who are likely to be eligible for state plan personal care or waiver" and inform them about self-directed options
  - States with Aging and Disability Resource Centers (ADRCs) have head start
- Provision for "a support system that ensures participants are appropriately assessed and counseled prior to enrollment and are able to manage their budgets"
  - Need to assess and counsel prior to enrollment and after to assure individuals can manage budgets – may be two separate efforts
  - ADRC could serve prior to enrollment function

Reporting requirements

- Annual report on the number of individuals served and total expenditures
- Evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years
  - Need data assessment and reassessment data for both SD and regular state plan and/or waiver participants
  - Most states will need to adapt assessment tools and data collection efforts to comply

Requirements for establishing service plan

- Assessment must address:
  - Needs
  - Strengths
  - Preferences
  - Requirement for incorporation of strengths and preferences in legislation departure from prior health and safety language
- Service plan
  - Must be person-centered
  - Build upon the "capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities
  - Involves families, friends, and professionals as desired or required by the participant
  - Incorporation of consumer control and community integration into legislation important principle

Requirements for establishing budget

- Based on an assessment and service plan
- Methodology:
  - Valid, reliable cost data
  - Open to public inspection
  - Includes a calculation of the expected cost if not self-directed
- May not restrict access to other medically necessary care and services in the state plan, but not included in the budget
- Guidance regarding how HCBS rates are set new – states not subjected to these requirements under 1915(c) legislation
- States will get administrative rate for fiscal intermediary
  - CMS had been allowing payment for this as a service under 1915(c) authority

Quality Assurance and Risk Management

- Legislation only states, "*There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities*"
- Likely that CMS will refine these requirements through regulations and policies
  - Quality requirements under 1915(i) and CMS Quality Framework for 1915(c) may serve as models

Section 6083: State Option to Establish Non-Emergency Medical Transportation Program

- State plan option to establish a non-emergency medical transportation brokerage program for individuals eligible for medical assistance who have no other means of transportation
- Important for individuals not enrolled in a waiver program that covers transportation
- Effective on the date of enactment

Grant Programs to Alter How States Deliver LTC

- Money Follows the Person Rebalancing Demonstration
- Rural PACE

Section 6071: Money Follows the Person Rebalancing Demonstration - Overview

- Provide incentives for states to move people from institutions to community settings
- 2-5 year competitive grants which will provide an enhanced federal medical assistance percentage (FMAP) for services to an individual for the first year after the individual moves out of an institution to the community
- The enhanced FMAP will be equal to the state's regular FMAP plus half of the difference between the regular FMAP and 100 percent.
  - No state may receive more than 90 percent federal match
- Appropriations of $1.75 billion made for grants from January 1, 2007 to September 30, 2011

Goals of Demonstration

- REBALANCING- Increase the use of home and community-based, rather than institutional, long-term care services
- MONEY FOLLOWS THE PERSON- Eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice

Major Requirements for Program,

- Eligibility – restricted to individuals who meet the following criteria:
  - Residing in an inpatient facility for a period of no less than 6 months
    - States can define a longer minimum term of up to 2 years
    - Inpatient facility defined as hospital, nursing facility, or ICF-MR
    - IMD only eligible if already covered under Medicaid state plan
  - Inpatient care is paid for by Medicaid
  - Still meet the level of care (LOC) criteria

Grant Proposal Requirements

- Must specify the methods to be used to increase HCBS spending (i.e., contribute to rebalancing)
- Must describe how the MFP Demonstration will contribute to rebalancing efforts
- Must describe the methods to be used to eliminate barriers to flexibility to pay for services in the appropriate settings of their choice, including transition costs (i.e., contribute to MFP)
- Must request any necessary modifications to waivers at the same time as the proposal

Selection Criteria for Grantees

- Shall attempt to have a balance in terms of:
  - Geographic
  - Disability populations
- Preference for applications that include:
  - multiple target groups
  - self-directed services

Language that Increases CMS' Oversight Ability

- Grant can be rescinded if CMS not satisfied with progress towards rebalancing the system or quality of care
- Unused amounts carryover for the next 4 fiscal years if grant not rescinded
- CMS will add rescinded grant funds to available award pool
- Cannot bill Medicaid and double dip

Research and evaluation contract

- Provide research on and a national evaluation that includes an analysis of projected and actual savings
- Final report by 9/30/2011
- $1.1 million in funding

Total appropriations for the grants - $1.75 Billion over 5 years

- $250 million for 1/1/07 to 9/30/07
- $300 million for fiscal year 2008
- $350 million for fiscal year 2009
- $400 million for fiscal year 2010
- $450 million for fiscal year 2011
- Amounts are available for the awarding of grants to states until September 30, 2011

Section 5302: Rural PACE Provider Grant Program

- Effort to build Program for All-Inclusive Care for the Elderly (PACE) programs in rural area
- $7.5 million appropriated in FY 2006
  - Up to 15 grants
  - Awards of up to $750,000
  - Because of appropriation must award either fewer than 15 or less than $750k
  - Grants must be awarded by 9/30/2006
  - Grants must be completed by 9/30/2008
- Cost Outlier Protection - HHS will establish an outlier fund to reimburse rural PACE pilot sites for recognized outlier costs equal to 80 percent of the amount over $50,000

EFFORTS TO INCREASE HCBS OPTIONS FOR CHILDREN

- HCBS Alternatives to Residential Treatment Facilities Demonstration
- Family Opportunity Act
- Family-to-Family Health Information Centers

Section 6063: HCBS Alternatives to Psychiatric Residential Treatment Facilities Demonstration

- Purpose - test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing HCBS to psychiatric residential treatment for children
- 5 year demonstration project
- Up to 10 states
- The program is authorized for fiscal years 2007 through 2011

Section 6062: Family Opportunity Act

- States plan option to allow parents of children with severe disabilities with income at or below 300 percent of FPL the ability to buy into Medicaid
- states can require cost-sharing but cannot exceed:
  - 5 percent of family income up to 200 percent of FPL
  - 7.5 percent of family income from 200- 300 percent of FPL
- Implementation is phased in with youngest children beginning with youngest children beginning in 2007

Section 6064: Development and Support of Family-to-Family Health Information Centers

- Number of states covered
  - at least 25 states in FY 2007
  - 40 states in FY 2008
  - All states in FY 2009
- Provide information to parents of children with disabilities and special health needs so that they can make informed decisions about health care

Tightening of Medicaid Eligibility

- Lengthening look-back period
- Disqualification for Medicaid long-term care benefits for individuals with substantial home equity

Section 6011: Lengthening Look-Back Period

- Extend the "look-back" period from 3 years (previous law) to 5 years
- Any asset transfers made for less than fair market value in the 5 years before application will be treated as if the individual still has the assets
- Requirement for states to establish a hardship waiver process with an appeals process
  - Undue hardship is defined as depriving the individual of medical care and endangering health or life or would deprive the individual of food, clothing, shelter or other necessities of life
- Effective on the day of enactment

Section 6014: Disqualification for LTC Assistance for Individuals with Substantial Home Equity

- Individuals will not be eligible for Medicaid nursing or other long-term care services if the equity interest in home exceeds $500,000
  - States may increase the equity limit up to $750,000
  - Beginning in 2011, the dollar limits will be increased yearly consistent with increases in the consumer price index
- Does not apply if the individual's spouse, child under 21, or disabled adult child in the home
- Individuals can use reverse mortgages or home equity loans to reduce equity value
- HHS will establish a hardship waiver process
- Effective for individuals determined eligible for LTC on or after January 1, 2006

Section 6021: Expansion of State Long Term Care Partnership Program Section

- Allows all states to develop Long Term Care Partnership programs, beyond the original 4 states – CA, CT, IN, NY
- Partnership programs allow individuals who have exhausted benefits of their private LTCI to access Medicaid without the same means-testing requirements
- Creation of National Clearinghouse for Long-Term Care Information
  - Info about state-specific Medicaid funded LTC
  - Provide objective info about LTCI
  - Maintain a list of partnership LTCI policies
  - $3 million per year
  - Through contract or interagency agreement
- To qualify, states and the insurance plans must meet extensive federal requirements

Increases in Cost Sharing Authority

- State option for alternative premiums and costs sharing
- Special cost sharing for prescription drugs
- Cost share for non-emergency treatment provided in emergency rooms

Section 6041: State Option for Alternative Medicaid Premiums and Cost Sharing Section

- Creates a new state option to increase cost sharing for any group of Medicaid beneficiaries
- Cost sharing can be imposed and/or increased for any item (e.g. prescription drug, durable medical equipment) or service (e.g. hospital stay, doctor's visit, occupational, physical, or speech therapy session)
- Limitations:
  - below 100% of Federal Poverty Level (FPL) – no more than nominal copays
  - 100 – 150% FPL – cannot be more than 10% of item or services
  - 150% + - Cost sharing can't be more than 20 percent of cost of item or service
  - No Premiums for: those in hospitals, ICF/MR residents, nursing homes, (i.e. anyone on a personal needs allowance (PNA)
  - Total cost sharing amounts are capped for all of the above groups at 5% of total family income for a month or quarter

Section 6041: State Option for Alternative Medicaid Premiums and Cost Sharing Section

- States may allow Medicaid providers to deny any "care, item or service" to a Medicaid beneficiary who fails to pay a co-pay.
- HHS must increase "nominal" cost sharing amounts every year by the annual percentage increase in the medical care component of the consumer price index, beginning in 2006
- The effective date of this provision is March 31, 2006

Section 6042: Special Rules for Cost Sharing for Prescription Drugs

- Allows states to impose higher cost sharing to non-preferred (typically brand name) medications
- Individuals with income below 150% FPL cannot be charged more than nominal cost sharing
- States can reduce or waive co-pays for preferred drugs
- If income is 150% or above FPL, co-pay for non-preferred drugs cannot exceed 20 percent of the drug's cost
- States can waive these rules if a physician determines that a preferred drug is not effective or causes adverse health effects, the state can charge the preferred (generic) co-pay amount for a non-preferred (brand name) drug
- Effective March 31, 2006

Section 6043: Emergency Room Co-payments for Non-Emergency Care

- Creates state plan option to allow hospitals to impose cost sharing for non-emergency services
- The beneficiary must receive a medical screening and a determination by the emergency room that the beneficiary does not have an emergency medical condition.
- Beneficiary must be told that
  - the hospital can require a co-pay
  - the name and location of an alternate non-emergency provider (that is available and accessible) that may charge a lower co-pay
- Co-pays for beneficiaries under 100% FPL cannot be more than twice the nominal amount
- Effective on January 1, 2007

FRAUD AND ABUSE PREVENTION

- Incentives for states to address fraud
- State requirements to prevent fraud and abuse
- National Medicaid Integrity Program
- Enhances efforts to collect third party payment
- Increases requirements for documentation of citizenship
- Review of disability determinations

Section 6032: Encouraging the Enactment of State False Claims Acts Section

- Incentive for states to have in effect a law dealing with false or fraudulent claims
- If states have such a law in place, when recoveries are made, the share owed to the federal government will be decreased by 10 percentage points
- Effective on January 1, 2007

Section 6033: Employee Education About False Claims Recovery Section

- States must ensure that any entity receiving Medicaid payments of at least $5 million per year must establish written policies with information about the federal False Claims Act
- State have laws regarding:
  - civil or criminal penalties for false claims and statements
  - whistleblower protections with respect to preventing and detecting fraud, waste, and abuse in federal health care programs
- Effective on January 1, 2007
  - States requiring new legislation will not be found non-compliant before the first quarter after the next regular session of the state legislature after enactment

Section 6034: Medicaid Integrity Program

- Establish a Medicaid Integrity Program
- HHS contracts with eligible entities to:
  - review actions of individuals or organizations providing items and services reimbursed by Medicaid;
  - audit payment claims;
  - identify Medicaid overpayments to individuals or organizations; and
  - educate service providers, managed care organizations, beneficiaries, and other individuals regarding payment integrity and benefit quality assurance issues
- Funds are appropriated for Fiscal Year 2006 and beyond

Section 6035: Enhancing Third Party Identification and Payment Section

- States must determine if third party liability exists for additional entities:
  - self-insured health plans;
  - pharmacy benefit managers; and
  - other parties legally liable by statute, contract, or agreement for payment of a health care claim or services.
- These organizations would be prohibited from taking an individual's Medicaid status into account in enrollment or making payments
- Effective on January 1, 2007
  - States requiring new legislation will not be found non-compliant before the first quarter after the next regular session of the state legislature after enactment

Section 6036: Improved Enforcement of Documentation Requirements

- Individuals must present documentation of citizenship or nationality when they apply for Medicaid
- Failure to present such documentation will make them ineligible for Medicaid services
- Documentation includes a U.S. passport, Certificate of Naturalization (or other specific forms used by the Immigration and Naturalization Service), a birth certificate, valid driver's license or other documentation which the U.S. Secretary of Health and Human Services specifies is proof of U.S. citizenship or naturalization
- Effective July 1, 2006
- HHS must develop an outreach plan to educate individuals who are likely to be affected by these provisions

Section 7501: Review of State Agency Blindness and Disability Determinations

- Social Security Administration (SSA) must review eligibility decisions made by the state disability determination agencies for people age 18 or older, before payments begin
- These "pre-effectuation reviews," are already conducted for people in the Old Age, Survivors, and Disability Insurance Program (OASDI) and for SSI beneficiaries who also receive OASDI benefits
- SSA Commissioner will review:
  - 20 percent of all disability decisions in FY 2006
  - 40 percent in 2007
  - 50 percent in 2008 or later.

Katrina Relief Section 6201-6203:

- Funds for Hurricane Katrina-related Medicaid waivers,
- $2.07 billion in 2006,
- $2.14 billion from 2006-2010.
- Pay eligible States for the non-Federal share of expenditures for health care for Katrina evacuees
- Funding for high-risk pools that States operate for Katrina evacuees who cannot otherwise obtain health insurance

Implications - Access

- Further restrictions on Medicaid as long-term care safety net for middle class
- May see another round of refinancing of state-funded services
  - Possible expansion as draw down FFP
- Precedents encouraging more efficient operations
  - Independent assessment
  - Assessment protocols that result in needs based plans of care
- Precedents that may begin the shift from a provider focused system
  - Requirements to inform individuals about self-directed options
  - Endorsement of person-centered planning

Implications - Quality management

- States currently trying to cope with implications of CMS HCBS Quality Framework requirements
- DRA does not explicitly endorse or codify these efforts
- DRA potentially sets in motion a process that could result in different requirements
- Best hope is for AHQR and CMS to merge efforts

Implications - Reimbursement

- Previously – major criteria had been HCBS had to be less than institutional care on average
- Sets precedent of budgets and plans of care being based on needs-based assessments
- Could set the stage for denial of reimbursement for services for which there is not a documented need