Provisions of the Affordable Care Act

Long Term Care Reform Workgroup

August 5, 2011

The Affordable Care Act (ACA)

- Supports most integrated setting, person-centered planning, and individual control
- Focus on integrating and linking services such as behavioral, acute, primary, and long-term supports
- Includes increased focus on quality and accountability
- Creates a special focus on individuals who are dually-eligible for Medicare and Medicaid
- Offers new or improved home and community-based services (HCBS) State Plan options
- Offers enhanced Federal funding to help states modify delivery systems

Key Provisions

- Health Homes
- Balancing Incentive Payment Program
- Money Follows the Person Demonstration
- 1915(i) Option
- Community First Choice: 1915(k)

Section 2703: Health Homes for Individuals with Chronic Conditions

Health Homes

- The Affordable Care Act option to develop a “health home” for individuals with chronic conditions who are on Medicaid.
- Patient centered medical homes (PCMH) should have:
  - a personal physician,
  - physician-directed medical practice,
  - whole-person orientation,
  - coordinated care,
  - quality and safety,
  - enhanced access,
  - and adequate payment.

Health Homes: Eligibility

Eligible chronic conditions are:

- a mental health condition,
- a substance use disorder,
- asthma,
- diabetes,
- heart disease, or
- being overweight.

* *this list may be considered for expansion*

Individuals must have:

- at least 2 chronic conditions,
- 1 chronic condition and be at risk for another, or
- 1 serious and persistent mental health condition.

- States may further limit eligibility criteria, *e.g.*, based on diagnosis.
- States must offer to all enrollees who meet the eligibility criteria.
- States may not exclude individuals dually eligible for Medicare.
- States <u>can limit</u> the geographic area where the program is offered.

Health Homes: Service Definitions

The following health home services are to be provided in a comprehensive, timely, and high quality fashion:

- comprehensive case management,
- care coordination and health promotion,
- comprehensive transitional care,
- individual and family support,
- referral to community and social support services, and
- the use of health information technology to link services.

Health Homes: Providers

- States may offer health home services from any of the following three types of health home provider arrangements:
  - designated providers, such as physicians, nurse coordinators, nutritionists, social workers, and behavioral health professionals;
  - a team of health care professionals, which links to a designated provider and may include home health agencies and community mental health centers; or
  - a health team, defined in law as community-based interdisciplinary teams that support providers of health home services.
- States cannot limit the program to only a few providers within a provider type; it must offer to all providers who meet the provider eligibility rules.

Health Homes: Other Provisions

- The payment methodology permits flexibility with CMS approval.
- States receive an enhanced Federal Medical Assistance Percentage (FMAP) of 90% for the first eight fiscal quarters.
- States must:
  - consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA)
  - collect and report information, and
  - participate in CMS' evaluation and assessment by an independent organization no later than January 1, 2017.

Section 10202: Balancing Incentive Payments Program

Balancing Incentive Payments Program (BIPP)

- Incentive for States to rebalance long-term services and supports (LTSS) systems
- Offers an enhanced federal payment rate for all HCBS covered during the “balancing incentive period”
  - October 1, 2011 through September 30, 2015
- Enhanced federal payment rates
  - 2% for states with less than 50% of LTSS spending in non-institutional settings
  - 5% for states with less than 25% LTSS spending in non-institutional settings
- Maryland qualifies for the 2% enhanced payment rate

BIPP Requirements

- All enhanced federal payments must be used to fund new and expanded Medicaid community-based LTSS
- Within six months, states must initiate “structural changes” to their LTSS systems that include:
  - Creation of a **Single Point of Entry** system for LTSS
  - Development of a **Standardized Assessment Instrument**
  - Implementation of **Conflict Free Case Management**
- By the end of the BIPP period states must:
  - Increase HCBS to 50 or 25% of total Medicaid LTSS spending
  - Maryland would have to increase HCBS spending to 50% of all LTSS expenditures by September 30, 2015

BIPP Single Point of Entry

- States must develop a statewide system for access to all long-term services and supports
- Single Points of Entry must provide information regarding
  - availability of services
  - how to apply for such services
  - referrals for services and supports available in the community
  - determinations or assistance with the assessment process for financial and functional eligibility
- Aligns with existing Maryland Access Point efforts

Standardized Assessment Instrument

- Develop and implement a core standardized assessment instrument for determining eligibility for community-based LTSS
  - To be used in a uniform manner throughout the state
- Determine a beneficiary's needs for
  - training
  - support services
  - medical care
  - transportation
  - other services
- Develop an individual service plan to address such needs

Conflict Free Case Management

- Develop and implement conflict-free case management services
  - meaning that the provider agency which is financially impacted by increased or decreased service utilization does not determine the level of services authorized under the care plan
- Case management services include
  - Development of a service plan
  - Coordinating services and supports
  - Assisting the beneficiary and their supporters in directing the provision of services
  - Conducting ongoing monitoring to assure that supports are delivered to meet the beneficiary's needs and achieve intended outcomes

Additional Requirements

States must

- Apply to participate
- Submit a budget and plan for increasing Medicaid HCBS spending to a target percentage by September 30, 2015
- Maintain eligibility levels for all non-institutional Medicaid services that were in effect December 31, 2010
- Complete new data collection regarding
  - services
  - quality data
  - outcome measures

Section 2403: Money Follows the Person

Money Follows the Person (MFP)

- Extended and expanded the MFP demonstration
  - MFP transitions can now occur through 2016
  - 43 States and the District of Columbia now participating
- Additional funding appropriated
  - $450 million for each Fiscal Year 2012 - 2016
  - Any unused portion of a State grant award is available to the State until 2020
- Offers States substantial resources and additional program flexibilities
  - 100% Federal funding for certain administrative costs

MFP Participant Eligibility Changes

Under the Deficit Reduction Act (DRA)

- 6 months of institutional stay
- At least 30 days of Medicaid benefits for inpatient services

Under ACA

- 90 days of institutional stay, excluding rehab stays
- At least 1 day of Medicaid benefits for inpatient services

Section 2402: 1915(i) State Plan Option

1915(i) State Plan Option

- State option to offer HCBS as a state plan benefit
- Has similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care now required under 1915(c) HCBS waivers
- Key Features
  - Allows waiver of comparability
  - Expanded service definitions
  - No “cap” on enrollment
  - No waiver of statewideness

Allowable 1915(i) Services

- 1915(c) services
  - Case Management
  - Homemaker
  - Home Health Aide
  - Personal Care
  - Adult Day Health
  - Habilitation
  - Respite Care
  - Other Services
- Chronic Mental Illness
  - Day Treatment
  - Partial Hospitalization
  - Psychosocial Rehab
  - Clinic Services

1915(i) Participant Eligibility

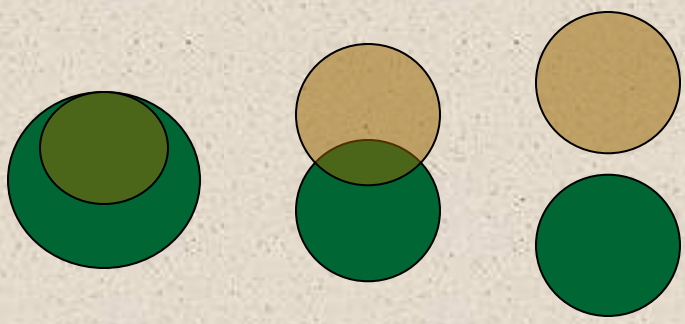
- Must be eligible for Medicaid under the State Plan
- Must reside in the community
- Must have income that does not exceed 150% of Federal Poverty Level (FPL)
  - States also have the option to include individuals with incomes up to 300% of SSI and who meet institutional level of care
- Must meet needs-based criteria established by the State

1915(i) Needs-Based Criteria

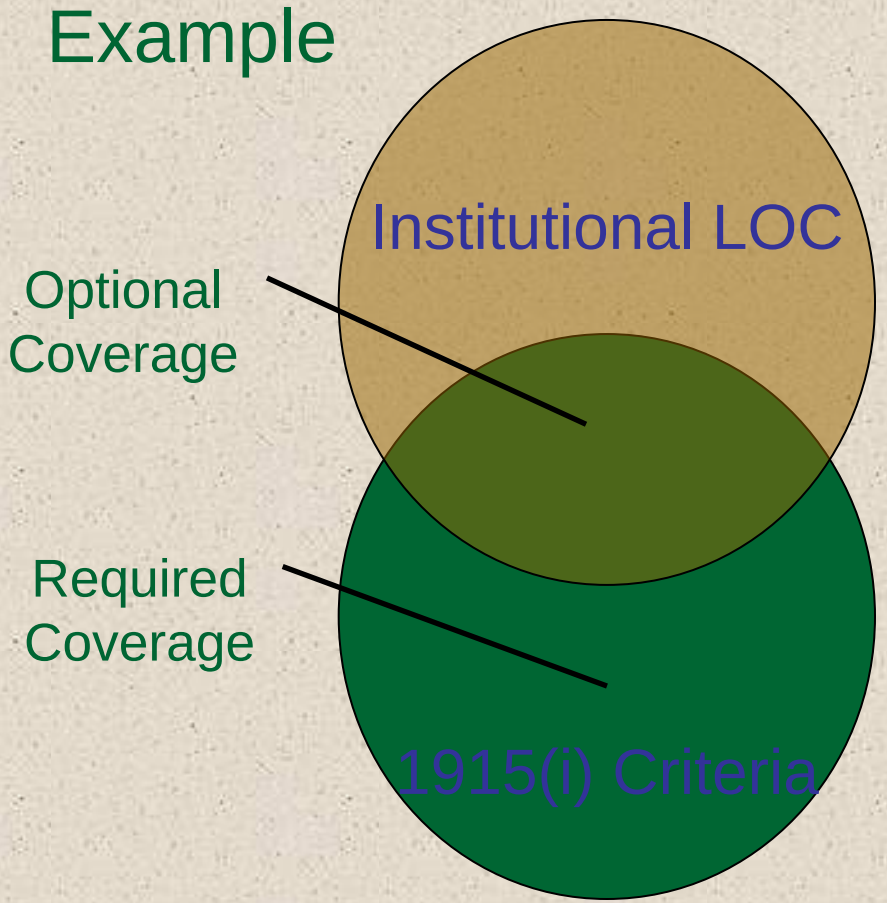
- Determined by an individualized evaluation of need
  - May be functional criteria such as Activities of Daily Living (ADLs)
  - May include State-defined risk factors
- Must be “less stringent” than institutional and HCBS waiver level of care (LOC)
- May include individuals at institutional LOC
- Needs-based criteria are not:
  - descriptive characteristics of the person
  - a diagnosis
  - population characteristics
  - institutional levels of care

1915(i) Needs-Based Criteria

- Eligibility criteria for 1915(i) benefit may be narrow or broad
- 1915(i) eligibility criteria may overlap all, part, or none, of the institutional LOC



Example



1915(i) vs.1915(c) Waivers

Similarities

- Independent evaluation to determine program eligibility
- Assessment of need for services
- Individualized plan of care
- Quality Assurance requirements
- Service Options
- Self-Direction Option

Section 2401: Community First Choice

Community First Choice (CFC)

- Adds Section 1915(k) to the Social Security Act
- Optional State Plan benefit to offer Attendant Care and related supports to individuals, providing opportunities for self-direction.
- Includes 6% enhanced FMAP.
- Provided on a Statewide basis.
- Notice of Proposed Rule-Making (NPRM) was Published on February 22, 2011.
- Effective October 1, 2011.

Who May Receive CFC services?

- Must be eligible for Medicaid under the State Plan.
- Income up to 150% of FPL, or if greater, meet an institutional level of care.

CFC Services

- Attendant services and supports to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing.
- Purchase of back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports.
- The State must develop and offer a voluntary training to individuals on how to select, manage and dismiss attendants.

CFC Services - State Options

Permissible services and supports.

- Allows for transition costs such as security deposits for an apartment or utilities, purchasing bedding, basic kitchen supplies, and other necessities required for transition from an institution.
- Allows for the provision of services that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistance.

Excluded Services

- Room and board.
- Special education and related services provided under the Individuals with Disabilities Education Act (IDEA) and vocational rehab.
- Assistive technology devices and assistive technology services (other than those used as back-up systems)
- Medical supplies and equipment.
- Home modifications.

Beneficiary Focus

- Utilizes a person-centered plan.
- Allows for the provision of services to be self-directed under either an agency-provider model or a self-directed model with a service budget that may include:
  - vouchers;
  - direct cash payments; or
  - use of a financial management entity to assist in obtaining services.

State Incentives and Requirements

- FMAP increase of 6%.
- Collaborate with a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives.
- Establish and maintain a comprehensive continuous quality assurance system specifically for this service.
- Collect and report information for Federal oversight and the completion of a Federal evaluation.

Maintenance of Expenditures

- Maintenance of existing programs – For the first full fiscal year in which the State Plan amendment is implemented, the state must maintain or exceed the level of expenditures for services previously provided under the State Plan, waivers or demonstrations.

CMS Requirements

- CMS is required by 12/31/15 to conduct an evaluation in order to determine:
  - the effectiveness of this provision in allowing individuals to lead an independent life to the maximum extent possible,
  - the impact on physical and emotional health of individuals receiving these services, and
  - a comparative analysis of the costs of services provided under Community First Choice and those provided in an institution.
- An interim report of this evaluation is due to Congress by 12/31/13.