MEMORANDUM

TO: MEMBERS OF THE GLOBAL WAIVER TASK FORCE

FROM: ELENA NICOLELLA

SUBJECT: NEW OPTIONS FOR ENHANCING THE AVAILABILITY OF MEDICAID-FUNDED LONG-TERM CARE SERVICES AND SUPPORTS

DATE: 7/11/2011

CC: LT. GOVERNOR LONG-TERM CARE COORDINATING COUNCIL

Several members of the Global Waiver Task Force have requested an understanding of how the Medicaid program intends to pursue some of the new opportunities related to long-term care services and supports available under the Affordable Care Act (ACA). This communication is intended to provide a summary of these new opportunities. While Rhode Island Medicaid is committed to taking full advantage of these opportunities, it should be noted that CMS has yet to transmit actionable guidance on many of the initiatives. As we await that guidance, we are working with other EOHHS agencies to analyze our existing efforts in this area and to develop strategies to integrate the new opportunities. We have also been accepted as a participating state in the Center for Health Care Strategies' technical assistance initiative to facilitate efforts to rebalance the long-term care delivery system. We look forward to working with members of the Task Force as well as the Lieutenant Governor's Long-term Care Coordinating Council on these efforts and will continue to update both as more information is made available..

A goal of the Rhode Island Medicaid program is to rebalance the long-term care delivery and financing system. The provision of home and community-based services (HCBS) is vital to achieve the State's rebalancing goal. The Rhode Island Medicaid program is committed to ensuring that consumers have ample options to remain in their communities. The Affordable Care Act (ACA) provides Rhode Island with an opportunity to implement additional options and tools that support the provision and financing of Medicaid home and community-based services and improve consumer outcomes. The ACA contains five major provisions that are designed to give states additional options for financing HCBS through a combination of enhanced Medicaid matching payments, demonstrations, and new state plan options. This paper summarizes these ACA provisions and their potential for the Rhode Island Medicaid program.

1. Money Follows the Person Demonstration

The Money Follows the Person (MFP) grant was established in the Deficit Reduction Act (DRA) of 2005. The MFP demonstration provides enhanced match to states for Medicaid recipients who are in qualified long term care institutional facilities and want to return to community living and live in qualified residences. The ACA extended the time frame for the MFP demonstration through 2016, added $450 million to bring the total funds available to $2.25 billion, and reduced the institutional length-of-stay needed to qualify for MFP from 180 to 90 days.

The enhanced Federal Medicaid Assistance Percentage (FMAP) match is for approved qualified, demonstration, and supplemental home and community based services. The enhanced federal match for HCBS increased from the published rate of 52.97 percent (without stimulus funding) to approximately 76.5 percent. In addition, states may receive full (i.e. 100 percent) reimbursement for approved administrative costs associated with the delivery of MFP services. CMS has indicated that total administrative cannot exceed 20 percent of the grant award. The enhanced federal match must be used for HCBS or for making system wide investments that improve the delivery of community based care.

States were required to submit an Operational Protocol to the Centers on Medicare and Medicaid Services (CMS) in January 20l1. Rhode Island received notification in February 2011 that the grant demonstration was approved with Special Term and Conditions. The State was awarded a total of $24,570,450 for the period covering April 1, 2011 through March 31, 2016, with a first year grant of $2,503,021. As requested by CMS, RI Medicaid submitted a revised Operational Protocol in March 2011. CMS must approve the revised Operational Protocol before implementing MFP. We are currently awaiting that approval.

2. State Balancing Incentive Payments Program

The State Balancing Incentive Payments Program (SBIPP) provides enhanced federal matching funds to states that implement initiatives that increase the proportion of long-term care expenditures for HCBS. SBIPP is available starting on October 1, 2011.

States that spend less than 25 percent of their long-term care expenditures on HCBS services will be eligible for an additional five percent match from the federal government for HCBS. States that spend less than less than 50 percent of their long-term care expenditures on HCBS services will be eligible for an additional two percent match from the federal government for HCBS. Rhode Island will likely fall into the first category (i.e. 25 percent) if the costs for serving persons with developmental disabilities are excluded in considering expenditures or fall into the second category (i.e. 50 percent) if the costs for serving persons with developmental disabilities are included in considering expenditures. RI Medicaid will seek guidance from CMS regarding how costs associated with serving persons with developmental disabilities should be treated. The enhanced federal match payments must be spent only on HCBS. The enhanced federal payments are provided during fiscal years 2012 through 2015.

To qualify for the enhanced federal payment, the State must submit a proposal to the Secretary of the federal Department of Health and Human Services (DHHS) that contains the State's plans and a budget to expand non-institutional services and supports. The State's plan must include the following structural attributes:

- A single point of entry for accessing long term care services and supports (LTSS),
- A standardized assessment tool for determining eligibility for non-institutional LTSS that is used state wide, and
- A conflict free case management system for consumers.

These structural requirements must be implemented within six months of submitting the application. States may not adopt more restrictive standards and methodologies for determining

eligibility for HCBS than was in effect in December 2010. The States must also collect data that measure services utilization, quality of care, and consumer outcomes.

By the end of 2015, Rhode Island will be expected to achieve the target of having 25 or 50 percent of its LTSS expenditures for HCBS.

Clearly, the SBIPP provides Rhode Island with increased match for HCBS. Final regulations on the SBIPP have not been released by CMS. There is much interest with how CMS will define "conflict-free case management" and the data collection requirements. Once the final regulations are released, RI Medicaid staff will assess the operational implications of the structural requirements of the SBIPP on the existing system in Rhode Island and determine that the State can meet federal requirements on a timely basis.

3. Community First Choice Option

The ACA established a new optional Medicaid state plan service called Community First Choice (CFC) Option under 1915 (k) of the Social Security Act. The CFC requires states to provide "person-centered" home and community-based attendant services and supports, statewide. CFC will be provided at an enhanced 6 percent rate beginning on October 1, 2011. Medicaid recipients are eligible for CFC with incomes up to 150 percent of the Federal Poverty Level (FPL) without meeting an institutional level of care. Individuals with incomes above 150 percent of the FPL must meet an institutional level of care.

Attendant services and supports must be consistent with the person-centered care plan developed based on a functional needs assessment. The services and supports must be provided by a qualified Medicaid provider or through a self-directed model. The self-directed model can be through an agency-provider agreement or through a traditional self-directed system with a service budget that may include vouchers, direct cash payments or use of a financial management entity to assist in obtaining services. Self-directed consumers must be trained on how to select, manage and dismiss attendants.

Attendant services and supports are those services required to assist individuals accomplish activities of daily living and health related tasks through hands-on assistance, supervision or cueing. Also allowable are the purchase of back-up systems or mechanisms to ensure the continuity of care and services, such as beepers and other electronic devices or other transitional costs to community based living (e.g. security deposits for an apartment or utilities, purchasing of bedding, kitchen supplies). Excluded services include: room and board, special education and related services provided under the IDEA and vocational rehabilitation, assistive technology devices and services (other than those used as back-up systems), medical supplies and equipment, and home modifications.

States are required to collaborate with a Development and Implementation Council that includes a majority of members with disabilities, elders and their representatives. A comprehensive quality assurance system must be developed and information provided to CMS for federal oversight and evaluation.

Final regulations on the CFC have not been released by CMS. RI Medicaid staff is currently in the process of assessing the potential of this provision on the current Personal Choice program, on the current attendant related HCBS services provided under the Global Waiver, and on the cost-

effectiveness of providing this service statewide to an expanded population beyond persons with disabilities and elders (e.g. Children with Special Health Care Needs). RI Medicaid staff will continue to consult with CMS on the CFC opportunity.

4. Amendments to Optional State Plan HCBS

ACA also made several amendments to optional State Plan HCBS initially adopted by DRA under Section 1915 (i) of the Social Security Act. Section 1915 (i) is used by some states as an alternative to Section 1915 (c) for providing HCBS. The revisions in ACA broaden the scope of covered services, provide less stringent needs based eligibility criteria to those who do not meet the state's institutional level of care, and allow the state to limit the amount, duration and scope of services to specific populations. However, the new amendments eliminate the state's ability to control growth through program enrollment ceilings, tighten needs based eligibility criteria, and require the state to implement the services statewide.

Rhode Island provides all HCBS services under an 1115 authority through the Global Waiver. Any additional flexibility offered under the expansion of 1915(i) is already available under the 1115 authority.

5. Dual Eligible Population

Through ACA, CMS has developed two new offices that will assist states to implement efforts around people eligible for Medicare and Medicaid (dual-eligibles). The Center for Medicare and Medicaid Innovation will explore innovations in health care delivery and payment systems that enhance quality of care for beneficiaries, improve the health of the populations, and lower the cost of care though program improvement efforts.

The Federal Coordinated Health Care Office will focus on the dual eligible population. Nationally, the dual eligible population account for 16 to 18 percent of the Medicare and Medicaid populations and roughly 25 to 45 percent of the cost. The approximately nine million individuals who are dual eligibles receive fragmented care though multiple delivery systems at a cost of over $300 billion in state and federal funds.

CMS is also funding State Demonstrations to Integrate Care for Dual Eligible Individuals. RI Medicaid applied for a planning grant to design a demonstration program. Only 15 states were selected to receive planning grants of up to $1 million each. Rhode Island was not one of the selected states. RI Medicaid has scheduled a debriefing with CMS to discuss the submitted proposal.