ANCOR American Network of Community Options and Resources

SHAPING POLICY • SHARING SOLUTIONS • STRENGTHENING COMMUNITY

Medicaid Sustainability:

Leveraging Federal Incentives to Encourage States to Expand Cost-Effective Home and Community Based Services

WHAT: Call for States to Capitalize on Multiple Opportunities for Medicaid Cost Containment and More Choices for People with Disabilities

FOR: ANCOR Members/State Associations to Advocate with Members of the U.S. Congress, State Government Officials and State Legislators

WHY: ANCOR is committed to the identification and promotion of innovative and promising strategies to ensure the long-term fiscal sustainability of federal and state Medicaid spending. People with significant disabilities rely on Medicaid for long-term supports and services (LTSS), and the potent combination of federal and state fiscal pressures and demographics demand that stakeholders work together to advance solutions.

The current health care environment is arguably more dynamic than it has been in nearly 50 years – since the creation of the Medicare and Medicaid programs. Sweeping changes are being made to the U.S. health care system at the national and state levels.

The goals of health care reform are: (1) expanded coverage, (2) controlled health care costs; and (3) an improved health care delivery system. Many of these changes have begun and will continue to impact the Medicaid program, individuals with intellectual and developmental disabilities (IDD) and the providers who serve them.

Individuals with IDD are diverse in their backgrounds and aspirations for the future, as well as in their degree of disability and required supports. Yet, all have disabilities and will require a variety of supports for the rest of their lives. And Medicaid is a primary funding source for these supports and services.

The supports and services available to people with IDD are defined, in part, by federal policy and funding, which is designed, co-funded and managed by states and provided in local communities. At the same time, the need to reduce the growth of Medicaid costs is clear. So it is imperative that we build new Medicaid and Medicare delivery systems – including the IDD system – that have the capacity to reduce costs without harming care. ***ANCOR encourages policymakers to have patience while cost savings are realized, and to continue to support and allow the maturation of these efforts.***

As a national policy and practice expert for providing long term community supports and services that ensure full citizenship and engage community participation for people with disabilities of all ages, ***ANCOR is committed to advancing Medicaid sustainability.***

Home- and community-based supports and services cost significantly less on average than institutional placement. On average, four people can be served in the community for the cost of one institutional placement (i.e., nursing homes and state institutions). Programs to incentivize states to realize these cost saving include the Balancing Incentives Payment Program (BIPP); Money Follows the Person (MFP); and optional State Plan services under §1915(i) and §1915(k), the latter also known as the Community First Choice option.

BALANCING INCENTIVE PAYMENT PROGRAM (BIPP)

BIPP is an incentive for states to rebalance LTSS systems. BIPP increases the Federal Medical Assistance Percentage (FMAP) to states that make structural reforms to increase access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that need to make fewer reforms. To participate in BIPP, a state must have spent less than 50 percent of total Medicaid medical assistance expenditures on non-institutionally based LTSS for fiscal year 2009. States that spent 25 to

percent on non-institutionally-based LTSS are eligible for a 2 percent enhanced FMAP, and states that spent less than 25 percent on non-institutionally based LTSS are eligible for 5 percent enhanced FMAP.

Some states have used this funding, combined with MFP grants, to provide community-based services and to reduce reliance on state institutions.

MONEY FOLLOWS THE PERSON GRANTS (MFP)

The Money Follows the Person (MFP) Rebalancing Demonstration was enacted as part of the Deficit Reduction Act of 2005. It is part of a comprehensive, coordinated strategy to assist states in reducing their reliance on institutional care while developing community-based, long-term care opportunities. The Affordable Care Act (ACA) extends the MFP demonstration through September 30, 2016, and shortens the amount of time an individual must be institutionalized in order to take advantage of the program from six months to 90 consecutive days. Most states and the District of Columbia (43) are participating. Additionally, any unused portion of a state grant award is available to the state until 2020. MFP offers states substantial resources and additional program flexibility including 100 percent federal funding for certain administrative costs. Many states are using MFP to downsize and/or close state institutions and transition people with disabilities out of nursing homes.

SECTION 1915(i) STATE PLAN OPTION

The Deficit Reduction Act of 2005 added section §1915(i) to the Social Security Act. This new §1915(i) state plan option breaks the "eligibility link" between home- and community-based services (HCBS) and the institutional level of care required by §1915(c) HCBS waivers, authorizing states to offer HCBS *without* requiring an individual to meet an institutional level of care. Any individual eligible for Medicaid State Plan services residing in the community with income at or below 150 percent of Federal Poverty Level is eligible to receive services under §1915(i). States also have the option to include individuals with incomes up to 300 percent of social security income (SSI) but who *do* meet an institutional level of care.

Although §1915(i) existed prior to the ACA, in order to promote state utilization of this option, the ACA included changes that enable states to target a package of HCBS to particular groups of people, make HCBS accessible to more individuals, and ensure the quality of the HCBS. Like current §1915(c) services, §1915(i) services might include case management, homemaker services, home health, personal care, adult day care, habilitation, respite care and more.

Section 1915(i) allows states flexibility in designing their HCBS benefit package, and it is particularly attractive in addressing the needs of those with behavioral health needs, because it provides for HCBS without requiring an institutional level of care. For people with chronic mental illness, services such as day treatment, partial hospitalization, psychosocial rehabilitation and clinic services that were previously difficult to attain through §1915(c) waivers or other Medicaid funding are now possible.

Section 1915(i) does not allow states to "cap" enrollment and, therefore, there are no waiting lists.

SECTION 1915(k) COMMUNITY FIRST CHOICE OPTION

Section 1915(k) is an optional State Plan benefit that provides opportunities for self-direction. If offered by a state, the services must be provided to any eligible individual on a statewide basis. States are incentivized to offer these services, as the option includes 6 percent enhanced FMAP with no date for expiration.

Funds can be used for attendant care services and supports to assist in accomplishing activities of daily living; purchasing back-up systems (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; training on how to select, manage and dismiss attendants; 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; services that increase independence or substitute for human assistance to the extent that expenditures would have been made for the human assistance.

Call for States to Leverage Federal Incentives to Expand the Utilization of Cost-Effective Home- and Community-Based Services