

# Federal Health Care Reform and its Potential Impact on California's Long-Term Care System

*This policy brief represents the written testimony presented to California's Little Hoover Commission at a public hearing on August 26, 2010 in Sacramento, CA. The SCAN Foundation's Director of Policy, Lisa Shugarman, PhD, was invited to present on Federal Health Care Reform and its potential impact on California's long-term care system. Her testimony to the Commissioners responds to three specific questions on this topic: (1) What are the long-term care provisions in the reform package?; (2) What new opportunities might be available – under health care reform or by way of modeling innovations made in other states – for California to expand its capacity to provide long-term care services?; and (3) How can we ensure that California takes advantage of these opportunities? This testimony refers to several provisions in the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148).*

Much of the focus of the new health care reform law involves improving health care coverage for the uninsured and underinsured. In addition to this critical goal, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) also lays the groundwork for wide-ranging continuum of care reform by establishing a framework for care coordination and integrated services across providers and settings. Currently, the continuum of care, composed of primary, acute, and rehabilitative medical services along with supportive long-term care services, is fragmented and unsustainable. The ACA presents many opportunities to improve long-term care, concurrently creating and strengthening linkages between medical care and supportive services.

## What are the long-term care provisions in the reform package?

Given the current absence of comprehensive long-term care financing, low consumer uptake of private long-term care insurance, and low savings rates among those nearing retirement, many middle-class aging boomers will likely have substantial difficulty paying for future long-term care needs. The few middle class protections that exist currently are only available for those

in nursing homes and not for those receiving services in the community, where individuals overwhelmingly prefer to live as they age.

The ACA presents a new era of long-term care reform beginning with the Community Living Assistance Services and Supports (CLASS) program. CLASS will, for the first time, provide the middle class with the opportunity to access supportive services in the setting of their choice without impoverishing themselves to Medicaid eligibility. CLASS fundamentally reframes the concept of long-term care from one of poverty, sickness, and loneliness to one of choice, community, and personal responsibility in the face of functional impairment.

The CLASS program represents the beginning of a public long-term care safety net based on a risk pool concept. CLASS is a voluntary, federally-administered insurance program for employed individuals with no exclusion for pre-existing conditions and offers a lifetime benefit for people with significant difficulty performing daily living tasks. Premiums will be age-rated, with younger people paying less and older adults more. A vesting period requires enrollees to pay premiums for at least five years prior to receiving benefits. Benefits would be cash payments averaging \$50 dollars a day for those certified to have substantial

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functional impairment and could be used to purchase a variety of supports and services, including home care, adult day programs, assisted living, or institutional care. Daily support provided by CLASS will offer a stable source of funding, potentially leading to the availability of more reliable home- and community-based services (HCBS) that strengthen the continuum of care.

#### *Medicaid Home and Community-Based Services Provisions in the ACA*

In addition to CLASS, the ACA contains several provisions allowing states to expand access to Medicaid HCBS, while also providing financial incentives through increased Medicaid federal matching rates.

- *Community First Choice*: The ACA establishes a new Medicaid State Plan option that provides community-based attendant services and supports to beneficiaries meeting the state’s criteria for nursing facility eligibility. States that choose this option will receive a six percentage point increase in their Federal Medicaid Assistance Payments (FMAP – the federal government’s share of the Medicaid program) for eligible services. Eligibility is limited to individuals with income levels at or below 150% of FPL, as well as individuals deemed eligible for an institutional level of care under the Medicaid State Plan. Not only will the Community First Choice option cover the costs of personal attendant services and supports, but it will allow states to use funds to cover the costs of community transition supports (e.g., rent/utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies) for eligible individuals who wish to return to the community. Through this provision, these and other covered services must be provided statewide and must be based on individual need rather than categorical

eligibility criteria (e.g., age, disability, etc.). This option will be effective October 1, 2011.

- *Medicaid Home and Community-Based Services State Plan Option*: The Deficit Reduction Act (DRA) of 2005 allowed states to amend Medicaid State Plans to include HCBS as an optional benefit (authorized as section 1915(i)). Since its inception, few states have opted for the 1915(i) State Plan option because of several programmatic limitations. The 1915(i) option is similar to the 1915(c) HCBS waiver, but does not require individuals to meet an institutional level of care in order to qualify. In addition, the 1915(c) waiver programs are allowed to enroll individuals with incomes up to 300% of SSI. The 1915(i) State Plan option, as written in the DRA, allowed enrollment of those with incomes up to 150% of the FPL, which is a more stringent income eligibility criterion than 300% of SSI. The 1915(i)’s restrictive eligibility criterion made it a less viable alternative for states interested in expanding access to HCBS. Now under the ACA, the 1915(i) option permits states to both extend HCBS enrollment to individuals with incomes up to 300% of SSI and offer the full range of Medicaid benefits to individuals receiving services through the 1915(i) option. Additionally, the law requires “statewideness” of services, meaning that the 1915(i) option must be made available to all eligible individuals. Revisions to the 1915(i) will be in effect starting October 1, 2010.
- *Money Follows the Person (MFP)*: Also established in the DRA, the Money Follows the Person demonstration was authorized through 2011 to assist eligible Medicaid beneficiaries residing in health or nursing facilities with transition from institutional settings to the community. The state’s FMAP increases for services provided to eligible individuals within

the first year of transition, in order to provide necessary services and supports for a successful transition. The ACA extended the MFP demonstration through September 2016, appropriated an additional \$2.25 billion, and shortened the institutional residency requirement from six months to 90 days. For states already participating in MFP, the Centers for Medicare and Medicaid Services (CMS) will not require submission of a grant proposal for additional funds. For states that are not currently participating in MFP, a grant solicitation was released in July 2010 and applications are due January 2011.

- *State Balancing Incentive Payments Program*: The ACA offers new financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into HCBS. Eligible states will be those that, in FY2009, spent less than 50% of total long-term care expenditures on HCBS. Qualifying states will receive an enhanced FMAP for the period FY2012-FY2015. States that allocate less than 25% of their total long-term care budget to HCBS will receive a 5 percentage point FMAP increase for related services. States that allocate between 25% to less than 50% of their total long-term care budget to HCBS will receive a 2 percentage point FMAP increase. States may increase the income eligibility standards for Medicaid HCBS. States choosing to participate in this program will be required to establish a “single entry point – no wrong door” system to streamline access to HCBS. This program will be in effect in October 2011 for states that meet the eligibility criteria and choose to apply.

#### *Other Related Provisions*

- Currently, states provide spousal impoverishment protections that allow spouses of individuals residing in

nursing facilities to retain additional income and assets to keep them from becoming impoverished. The ACA extends this protection to spouses of individuals residing in the community and receiving Medicaid-funded HCBS. This provision will be effective on January 1, 2014 for five years.

- *Aging and Disability Resource Centers (ADRCs)* serve as a single point of entry to assist individuals with disabilities and/or chronic conditions in accessing health care, medical care, social supports, and other long-term services and supports. The Administration on Aging (AoA) and CMS have funded one or more ADRCs in most states. The ACA appropriates additional funds and extends the ADRC program through 2014. The grant solicitation was released on May 31, 2010 and applications were due in July 2010.
- *Care Transitions Programs* are evidence-based service delivery protocols that seek to assist high-risk individuals with a smooth transition back to the community following a hospital or rehabilitative nursing home episode. This provision, initially envisioned to target hospitals with high re-admission rates, is joined with the ADRC grant solicitation described above and will provide funds to states that have previously received an ADRC or Hospital Discharge Planning Grant Award.
- *Support for the Direct Care Workforce*: The ACA establishes two workforce-related governing bodies to examine issues including workforce supply, education and training, and retention practices. The Personal Care Attendants Workforce Advisory Panel was written into the CLASS Act to advise on issues related to the direct care workforce (nominations for this panel closed on June 18, 2010). The National Health Care Workforce Commission

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**“Medicaid Home and Community-Based Services Provisions in the ACA include Community First Choice, Medicaid Home and Community-Based Services State Plan Option, Money Follows the Person, and the State Balancing Incentive Payments Program.”**

will consider a broader array of the workforce but will incorporate issues related to the direct care workforce specifically (nominations for this panel closed on June 30, 2010). Two training grant solicitations have also been released by the Health Resources and Services Administration (HRSA) as directed by the ACA. The Personal and Home Care Aide State Training Program will establish demonstration programs in up to six states for the purposes of developing core competencies, pilot training curricula, and to develop certification programs for personal and home care aides (applications were due on July 19, 2010). The Nursing Assistant and Home Health Aide Program establishes a new three-year program for up to 10 community college and/or community-based training programs to provide support for the development, evaluation and demonstration of a competency-based curriculum for nursing assistants and home health aides (applications were due on July 22, 2010). Finally, the ACA established State Health Care Workforce Development Grants that will provide one-year grants to states to develop partnerships to produce a comprehensive health care workforce at the state and local levels. The grants will be a maximum of \$150,000, but will require each state grantee to provide a limited level of matching funds (applications were due on July 19, 2010).

Other important components of the ACA are outlined in the companion policy brief produced by The SCAN Foundation.<sup>1</sup> These include accountable care organizations, post-acute bundling pilots, medical/health homes, improvements to Medicare Part D, quality improvements for nursing homes, and the Elder Justice Act.

## **What new opportunities might be available – under health care reform or by way of modeling innovations made in other states – for California to expand its capacity to provide long-term care services?**

California has taken active steps to capitalize on various opportunities provided under the ACA. Below are some examples of California’s efforts to strengthen and build upon its long-term care system.

Of the four approaches to expanding Medi-Cal HCBS through the ACA, three are potentially viable options for California: Community First Choice, 1915(i), and Money Follows the Person (MFP). California is not a candidate for the State Balancing Incentive Payments option because the most recent data indicate that California invests approximately 52% of its long-term care dollars in HCBS.

The Community First Choice option is a potential opportunity for California to consider when it becomes effective in October 2011. However, further federal guidance is needed regarding eligibility provisions. As currently defined, the eligibility criteria would increase financial eligibility beyond California’s current standard, thereby bringing a greater financial burden to the state. In addition, many of the services authorized under Community First Choice are similar to what California provides under its In Home Supportive Services (IHSS) program. Therefore, it is not clear if this Community First Choice option would be a net benefit to the state.

The Medicaid HCBS State Plan option (1915(i)) is another alternative for California to consider. Currently, only four states offer the 1915(i) option. Many states have not chosen this option as it establishes an entitlement to HCBS beyond the current standard of nursing home eligibility, thereby making it cost-prohibitive. However, the revisions outlined in the ACA may make this option more appealing. The CMS directive to State Medicaid Directors provides further guidance to states, permitting design of a service package to specific, targeted populations. To that end, the Departments of Health Care Services, Rehabilitation, and Mental Health are in the process of developing a 1915(i) application to extend HCBS to residents with traumatic brain injury.

In 2007, California was awarded a grant to implement a MFP Demonstration project, called California Community Transitions. There are additional funds made available through the ACA to encourage states that have not yet applied for MFP to submit an application. Given that California is already a grantee, these funds are not relevant. However, the ACA also extends the MFP program through 2016 and reduces the number of days one must reside in an institution to be eligible for the MFP benefit from 180 days to 90 days. These eligibility changes may increase opportunities for the state to transition more nursing home residents back into the community.

Beyond expanding Medi-Cal HCBS through the provisions described above, California is seeking to maximize opportunities through three additional initiatives: ADRC expansion with Evidence-Based Care Transitions, Direct Care Workforce training, and the 1115 waiver application.

In response to the grant solicitation released by CMS and AoA at the end of May, the California Health and

Human Services Agency, the California Department of Health Care Services, and the California Department of Aging have submitted proposals to enhance and expand the role of ADRCs in the state. In total, four proposals were submitted to respond to each of the four components of the solicitation: 1) outreach and education to people likely eligible for benefits; 2) ADRC options counseling and assistance programs; 3) ADRC nursing home transition and diversion programs; and 4) ADRC evidence-based care transition programs. If awarded, the funds will help reinforce the information and assistance infrastructure in the state through a “single entry point” approach, as well as support the concepts of care coordination while expanding opportunities to receive HCBS. It is not known yet if the state will be awarded funds for these proposals.

California is also making strides to support the existing direct care workforce and plan for the workforce needs of the state going forward. Among other grant opportunities, the California Workforce Investment Board (State Board), in partnership with the California Office of Statewide Health Planning and Development (OSHPD), has submitted an application for one of the State Health Care Workforce Development Planning Grants authorized under the ACA. Specifically, the State Board requested \$150,000 to establish a Health Workforce Development Council. Through the Council, the State Board will convene public and private health workforce and education stakeholders in order to develop a comprehensive plan for health workforce development in California. Additionally, the Governor designated the California Community Colleges System as the lead for the state’s application under the Personal and Home Care State Training program. Pasadena City College took the lead in drafting the proposal. Finally, OSHPD provided technical assistance for and a letter of support to Solano Community College in support for its

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application under the Nursing Assistant and Home Health Aide program. The federal government is currently reviewing applications for this funding opportunity.

In addition to the responses to the opportunities in health care reform, the Department of Health Care Services has submitted an application to CMS for an 1115 waiver, which allows states to test out new approaches to organizing health care in the Medicaid program. As of August 26, 2010, California's 1115 waiver renewal application is pending CMS approval. The new waiver application continues the work of the prior waiver by seeking to expand the availability of health care coverage to more California residents through Medi-Cal. In addition, the new waiver seeks to improve care coordination for some of the state's most vulnerable residents, among them seniors and people with disabilities and those who are dually-eligible for Medicare and Medi-Cal. The dual eligible portion of the waiver application seeks to establish four pilot sites to test different approaches to integrating acute and long-term care services.

### **How can we ensure that California takes advantage of these opportunities?**

As noted above, California is pursuing many options both within and outside the health care reform law to reinforce and strengthen the state's long-term care system. But more can be done. Below are The SCAN Foundation's recommendations.

- Support the CLASS program. To ensure that CLASS is a healthy and vibrant insurance program operating alongside private long-term care insurance, it is imperative to have broad participation across all walks of life. This calls for a paradigm shift that combines

increasing personal responsibility for long-term care needs in partnership with government support, both of which are needed to achieve a sustainable, efficient long-term care system in California.

The state has an opportunity to support this national effort by encouraging residents to be more invested in their own futures through public education campaigns to inform residents of the high likelihood of needing long-term care in old age. Employers will also play a key role in educating and informing workers about the need for and opportunities in CLASS as well as assist employees with enrollment. State and local governments are collectively the largest employer in the state and should take the lead in making CLASS available to its employees. In addition, the state can help foster public/private partnerships with large and small employers alike to educate the general public about the availability of the CLASS insurance program.

- Help the State explore the potential to apply for enhanced Medicaid HCBS options. Of the four Medicaid HCBS expansion opportunities described previously, there are three that may be viable options for the state. Consistent with the recently disseminated State Medicaid Directors letter from CMS regarding the 1915(i) State Plan option, the opportunities available through the ACA are important tools for California to serve individuals in the most integrated setting possible, building a strong continuum of care, and meeting the state's obligations under the Americans with Disabilities Act and the Olmstead decision.
- Continue to identify ways to support and grow the direct care workforce. California has already taken great strides to help support the current and anticipated direct care workforce by submitting proposals to HRSA to access

funds available through the ACA. The outcome of these applications is still unknown. Regardless of whether California is awarded any funds through these mechanisms, the state will need to continue to identify ways to support and grow a well-trained direct care workforce. This is critical to ensuring an available and sufficiently trained workforce supply to address the increasing demand for services as the boomer population ages. It is also particularly important for CLASS program implementation, given that states will be required to have an adequate direct care workforce infrastructure as part of this provision.

- Pave the way to successful care coordination and service integration for vulnerable seniors and people with disabilities. Encourage the legislature and the next Administration to provide the necessary resources to ensure that the 1115 waiver proposal (if approved) is implemented successfully and in line with recommendations made by a diverse array of stakeholders through a careful and extended work group process throughout last year. The 1115 waiver, at its core, embraces the goal of care coordination whereby individuals and their loved ones are at the center of health and long-term care planning, decision making, and implementation. Efforts to transform the health and supportive service systems toward a care coordination approach for some of California's most vulnerable populations have great potential to impact the wider

service delivery systems serving others who are or will become vulnerable due to a chronic health condition or disability and require services in California.

## Conclusions

Through the implementation of ACA initiatives to improve access to community-based long-term care services, to encourage uptake of CLASS, to support increased access to ADRCs, and to grow the needed direct care workforce, a new system can be created that is truly greater than the sum of its parts. It is a system that will be better able to absorb the new and likely substantial demand for long-term care services created by a population that will grow exponentially in the next 20 years as a result of the aging of the boomer population. While it is far from perfect, the new health care reform law is an opportunity to transform long-term care and supports a vision that is person-centered, more accessible, affordable to all and offered in the most appropriate and preferred settings.

<sup>i</sup> The SCAN Foundation (2010). A Summary of the Patient Protection and Affordable Care Act (P.L. 11-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872). Accessed August 25, 2010 at: [http://www.thescanfoundation.org/sites/default/files/TSF%20Policy%20Brief%20No.%20%202%20Mar%20%202010%20-%20Side-by-Side\\_0.pdf](http://www.thescanfoundation.org/sites/default/files/TSF%20Policy%20Brief%20No.%20%202%20Mar%20%202010%20-%20Side-by-Side_0.pdf).