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National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

September 24, 2012

Medicaid Long Term Services and Supports 101

Advocate's Guide to Emerging Opportunities and Challenges

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The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Webinar Roadmap

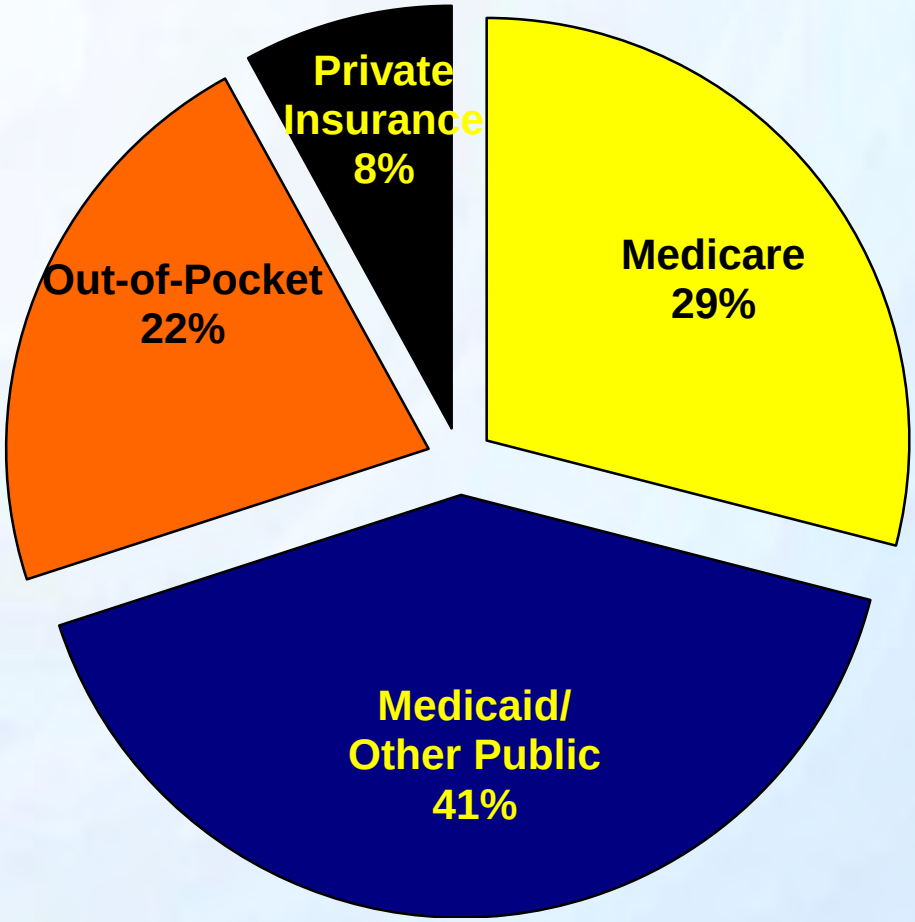
- Community-Based LTSS Options
- Legal Protections 101
- Advocacy Issues
  - Defending Access
  - Expanding Services
  - Shift to Managed Care

Medicaid Long Term Services and Supports (LTSS)

- Medicaid:
  - America's Health Care Safety-Net
  - joint state/federal program
  - primary payer for LTSS

- Medicaid LTSS Services:
  - Nursing Home (Medicare = max 100 days)
  - Home and Community-Based Services (HCBS):
    - Home Health, Personal Care Services (PCS), Adult Day (Health) Care, Homemaker Services, etc.

Total US Long-Term Care (LTC) Expenditures, 2011
$221 billion



Source: Historical National Health Expenditure Data, CMS 2011 (courtesy of C. Harrington)
https://www.cms.gov/nationalhealthexpenddata/02_nationalhealthaccountshistorical.asp

Medicaid's Community-Based LTSS Program Options

Medicaid LTSS Options

	Traditional State Plan (entitlement)	Waivers (CMS waives certain Medicaid rules)	Other Options
Mandatory	Nursing Home (51) Home Health (51)	---	---
Optional	Personal Care (32) Adult Day Care Personal Care Homemaker Services	1915(c): HCBS Waivers (300+) 1915(d): HCBS Waivers for Older Adults 1115a: Demonstrations (80+)	1915(j): Self-Dir. Personal Asst. PACE ACA additions: 1915(i): HCBS+ 1915(k): Community First Choice BIPP
Managed Care	State Plan Authority: 1932(a)	Waiver Authorities: 1915(a),1915(b), 1115a	

Different Programs, Different Rules

Traditional State Plan

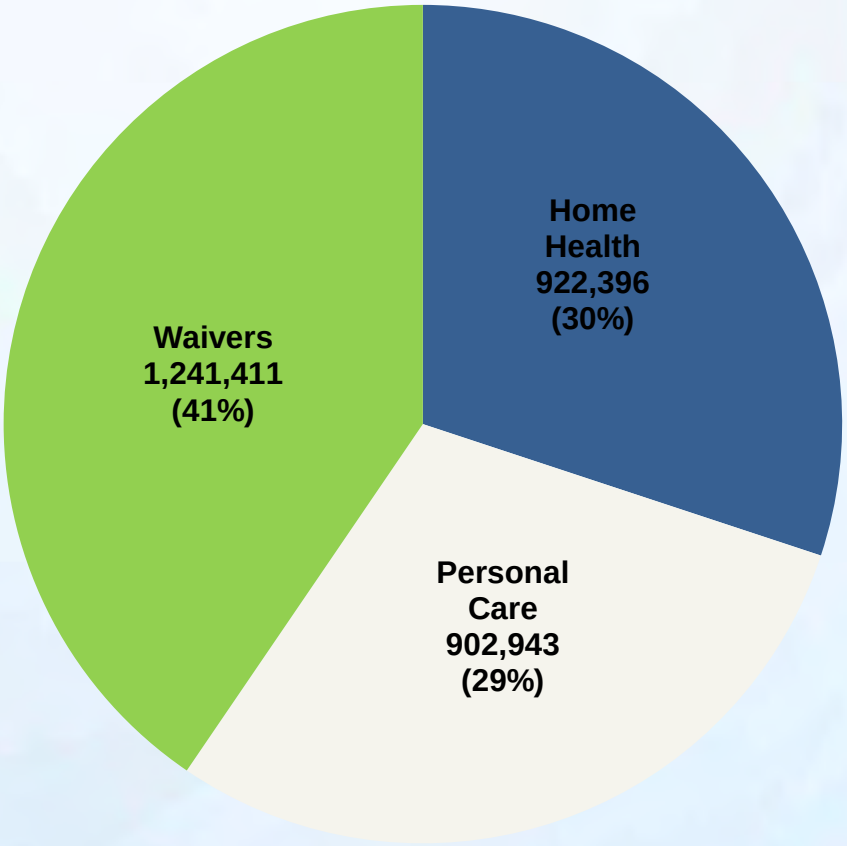
- Plans: 42 U.S.C. § 1396a(a)
- Services: 42 U.S.C. § 1396(d)(a)
- ENTITLEMENT
  - Statewide
  - Comparable
  - No Cost Caps

Section 1915(c) HCBS Waivers

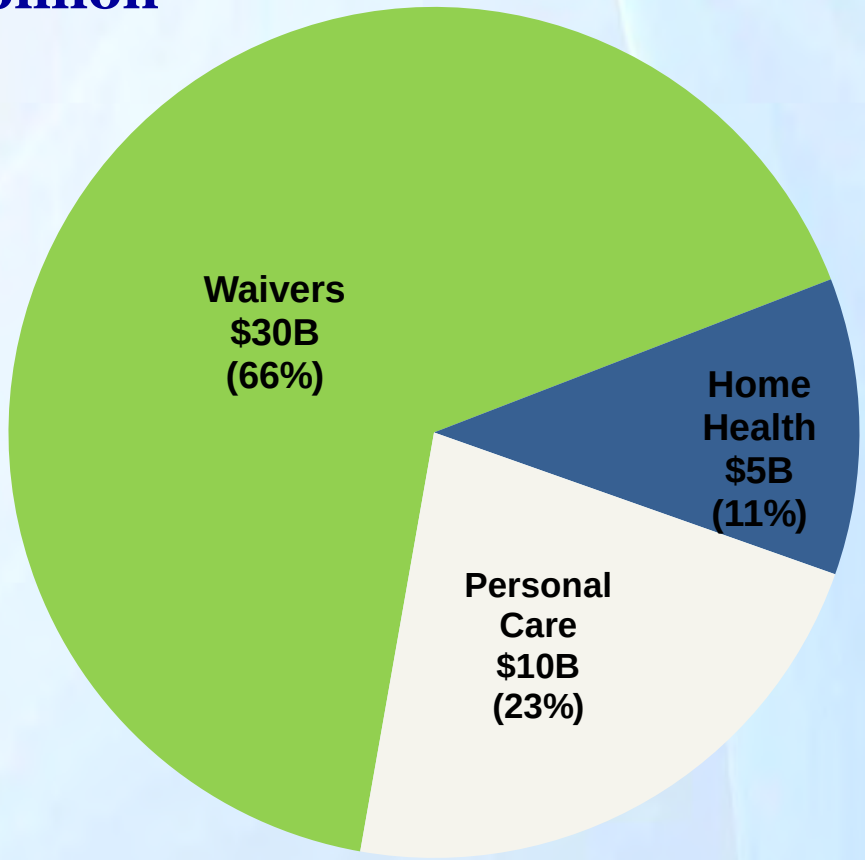
- 42 U.S.C. § 1396n(c)(1)
- Most Heavily Utilized HCBS option
- Quirks:
  - Cost limits
  - geographic/population targeting
  - enrollment caps (waiting lists!)

Medicaid HCBS Participants & Expenditures by Program, 2008

Total Participants: 3.07 million



Total Expenditures: $45 billion



Ng & Harrington , 2011. *Medicaid HCBS Program Data 92-08*. San Francisco, CA: UCSF

Medicaid

By Topic

Eligibility

Benefits

Cost Sharing

Waivers

Long-Term Services & Support

Delivery Systems

Quality of Care

Financing & Reimbursement

1915(c) Home & Community-Based Waivers

The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

More information on approved 1915(c) waivers in each state is available. Or, learn more about home and community based services delivery.

Section 1115 Demonstration Waivers

- 42 U.S.C. § 1315
- FLEXIBILITY (within limits)
  - CMS considers: experimental purpose, likelihood to promote Medicaid objectives, necessary extent and period
    - Newton-Nations v. Betlach (9th Cir. 2011)
- New Approval Process/Public Input Regs:
  - 42 C.F.R. § § 431.400-.428

Note: Distinct from 1115A (duals demos)

Medicaid

By Topic

Waivers

Section 1115 Demonstrations

Section 1115 Demonstrations

About Section 1115 Demonstrations

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

More Information

- About Section 1115 Demonstrations
- Pending Applications
- Public Comments
- How States Apply
- Section 1115 Demonstrations List

Other LTSS Options: 1915(i)

- HCBS state plan option
  - no institutional level of care requirement
  - must be statewide, but can target by population
  - states can choose from range of LTSS
  - more flexible financial eligibility

Other LTSS Options: 1915(j)

- Self-directed personal assistance services (PAS); either state option or waiver. Beneficiaries hire and train workers; person-centered plan.
  - May be allowed to hire spouses or parents.
  - May be allowed to manage cash budget, purchase items not on list.

Other LTSS Options: 1915(k)

- Community First Choice Option (CFCO)
  - Statewide option
  - "person-centered" LTSS
  - 6% enhanced federal match

Other LTSS Options: BIPP

- Balancing Incentives Payments Program
  - incentives for states to increase % spent on HCBS
  - <50% of LTC on HCBS = +2% fed match
  - <25% of LTC on HCBS = +5% fed match
- State HCBS Increase Strategies:
  - Need no wrong door for LTSS
  - standardized assessment
  - conflict-free case management

Legal Protections 101

Legal Protections: Potential Tools for Advocates…

- Disability Rights Laws
- Medicaid Act
  - Program-Specific Rules
  - General Requirements (watch for waivers!)
- Due Process

Don't forget state and local laws….

Disability Rights Laws

ADA, Title II: 42 U.S.C. § 12132

Rehab Act, Sec. 504: 29 U.S.C. § 794

- Methods of Administration:
  - 28 C.F.R. § 35.130(b)(3) (ADA)
  - 28 C.F.R. § 41.51(b)(3)(I) (Rehab Act)
  - 45 C.F.R. § 84.4(b)(4) (Rehab Act)

- Improper Eligibility Requirements:
  - 28 C.F.R. § 35.130(b)(8) (ADA)
  - 45 C.F.R. § 84.4(b)(1)(iv) (Rehab Act)

Disability Rights Laws

- Defense: Fundamental Alteration
  - Reasonable Modification
  - 28 C.F.R. § 35.130(b)(7) (ADA)
  - 28 C.F.R. § 41.53 (Rehab Act)

- Integration Mandate:
  - 28 C.F.R. § 35.130(d) (ADA)
  - 28 C.F.R. § 41.51(d) (Rehab Act)
  - *Olmstead v. L.C.*, 527 U.S. 581 (1999)
  - Legal Standard: Risk of Institutionalization

Medicaid Act

"Once a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations."

–*Alexander v. Choate*, 469 US 287, 289 n.1

- Federal Approval Requirement:
  - State Plan: 42 U.S.C. § 1396a(a); 42 C.F.R. § 430.12
  - HCBS Waiver: 42 U.S.C. § 1396n(c)(1)
- Statewideness Requirement (waiveable!):
  - 42 U.S.C. § 1396a(a)(1)
- Freedom of Choice Requirement (waiveable!):
  - 42 U.S.C. § 1396a(a)(23)

Medicaid Act, cont.

- Reasonable Promptness:
  - 42 U.S.C. § 1396a(a)(8) ; 42 C.F.R. § § 435.911, 435.930
- Comparability (waiveable!):
  - 42 U.S.C. § 1396a(a)(10)(B)(i) ; 42 C.F.R. § 440.240
- Reasonable Standards:
  - 42 U.S.C. § 1396a(a)(17) ; 42 C.F.R. § 440.230(c)
- Amount, Duration and Scope:
  - 42 C.F.R. § 440.230(b)
  - Purpose of Services:
    - Medicaid services generally: 42 U.S.C. § 1396-1
    - HCBS waiver services: 42 U.S.C. § 1396n(c)(1); 42 C.F.R. § 441.300

Due Process

Requirements:

- adequate, timely prior notice
  - adequacy = enables preparation of responsive defense
  - age and disability → increased need for detail
- opportunity for fair hearing
- aid paid pending decision on appeal

Authorities

- U.S. Const.:
  - amend XIV; *Goldberg v. Kelly*, 397 U.S. 254 (1970)
- Medicaid Act:
  - 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § § 431.200-431.250

Advocacy Issues

- Defense
- Expansion
- Shift to Managed Care

Defense: Budget-Driven Threats

- Service Reductions
  - Benefit caps/reduced hours
- Eligibility Restrictions
  - Heightened ADL/IADL requirements
- Service Eliminations
  - outright elimination, state plan →waiver
- Others: provider rate cuts, informal barriers

Defense: State Advocacy

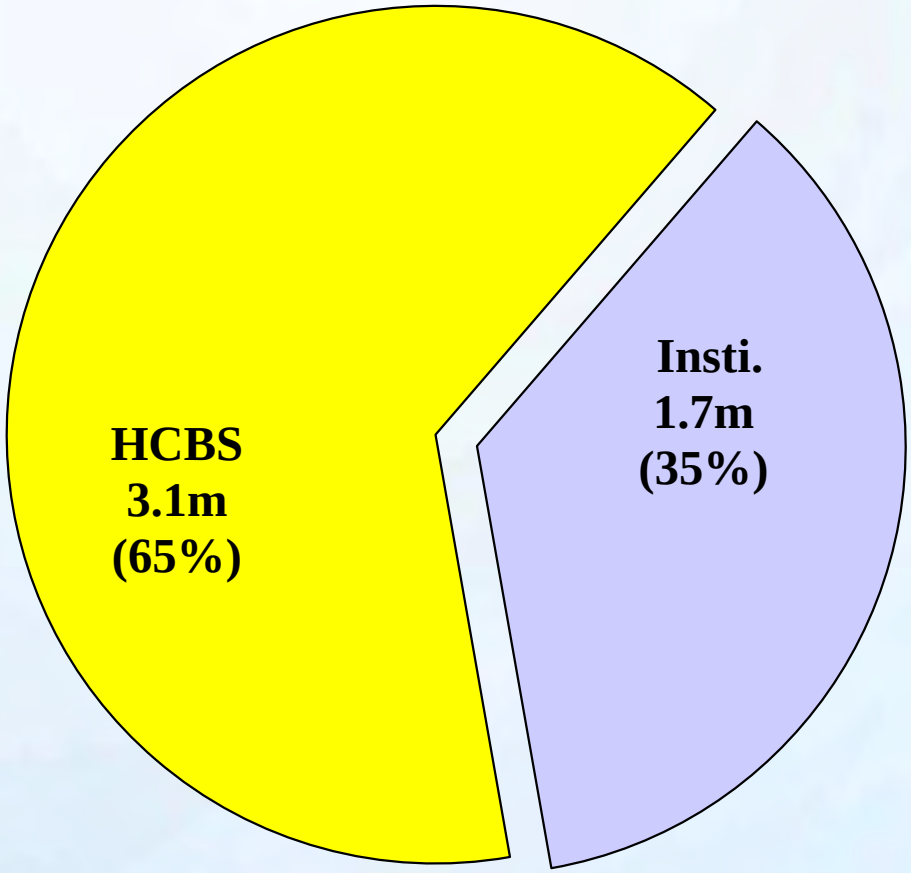
- Audiences:
  - Administrative Agencies
  - Legislatures
- Close Monitoring → Early Intervention
- Best Defense is Offense: Expand HCBS

LTSS Expansion

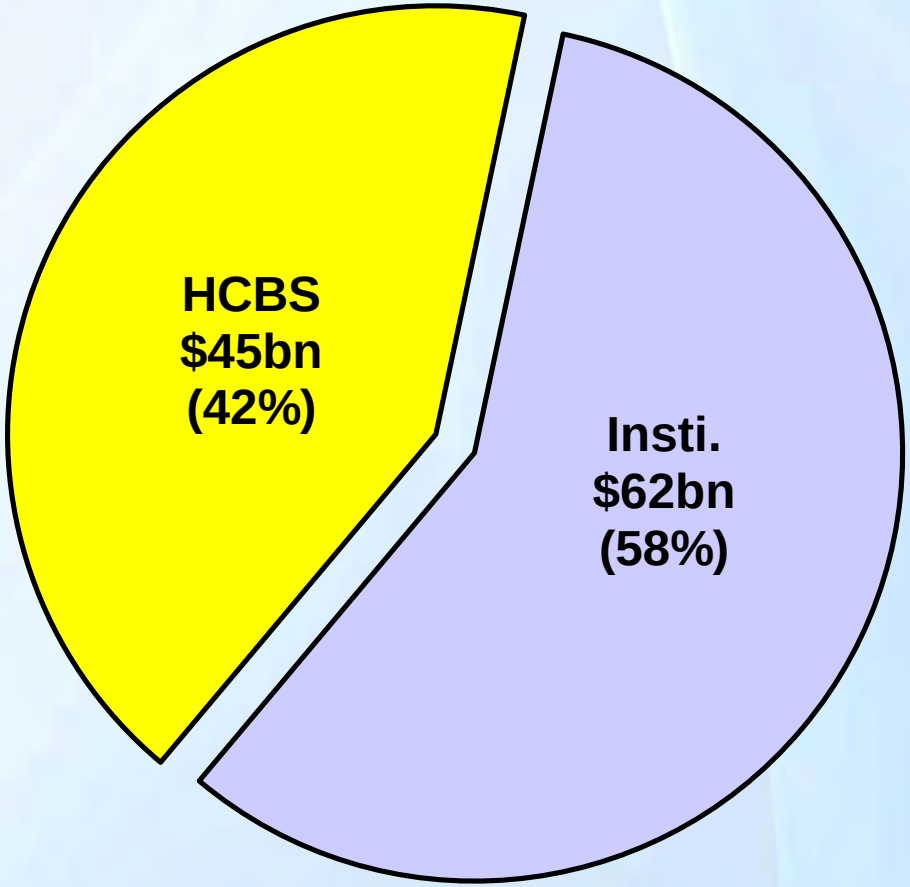
- Cost-Savings Arguments
- Do real cost-benefit analysis
  - Woodwork Effect Discredited
  - consider institutional savings (flexible accounting)
- Utilize New ACA Incentive Programs

The Institutional Bias in Medicaid LTC, 2008

Participants: 4.8 million



Expenditures: $107 billion



Source: HCBS (Ng and Harrington, 2011) , Institutional (CMS Form 64 Data, Medstat 2010; MSIS 2008 Data)

Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services

Recommendations for California

By

Leslie Hendrickson, Ph.D.
Laurel Mildred, MSW

January 2012

Supported by a grant from The SCAN Foundation, dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

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Gradual Rebalancing Of Medicaid Long-Term Services And Supports Saves Money And Serves More People, Statistical Model Shows

H. Stephen Kaye[1,*]

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Abstract

States are shifting Medicaid spending on long-term services and supports from institutional to home and community-based services, a process known as rebalancing. Using fifteen years of state expenditure data, a statistical model was developed to assess the effect of rebalancing on overall spending for long-term services and supports. The model indicates that spending is affected by the way rebalancing is implemented. Gradual rebalancing, by roughly two percentage points annually, can reduce spending by about 15 percent over ten years. More rapid rebalancing can save money, break even, or increase spending, depending on the pace and program specifics. Cuts to home and community-based services that hinder rebalancing are likely to increase, not decrease, overall spending on long-term services and supports as people who were receiving these services shift into nursing homes. Because many states continue to experience budget crises, policy makers must think carefully before altering spending patterns for long-term services and supports and adopt strategies that particular states have used to successfully reduce overall spending, such as gradually shifting expenditures toward home and community-based waiver programs.

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Home & Community-Based Services

[-] Services
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Payment Reform To Achieve Better Health Care

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BLOGS

HEALTH AFFAIRS | GRANTWATCH

1. What Do Polls Really Tell Us About The Public's View Of The

Defense: Federal Advocacy

- CMS (Medicaid)
  - Federal Approval requirement
    - for state plan amendments
    - for waiver creation and renewal
- HHS Office of Civil Rights (ADA/Rehab)
  - Formal vs. Informal Complaints
- Department of Justice (federal law)
  - Statements of Interest

ADA HOME PAGE

www.ada.gov

Information and Technical Assistance on the Americans with Disabilities Act

seal of the U.S. Department of Justice, ADA HOME PAGE, Information and Technical Assistance on the Americans with Disabilities Act

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Other Federal Agencies with ADA Responsibilities

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Public Transportation (DOT)

Telephone Relay Service (FCC)

Proposed Design Guidelines (Access Board)

U.S. Department of Justice

Americans with Disabilities Act

ADA HOME PAGE

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(updated September 18, 2012)

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Enforcing the ADA: A Status Report from the Department of Justice

ADA Mediation Program

Defense: Litigation

- Potentially Powerful Tool
- ADA/Medicaid Claims work together

Cautionary Notes:

- Enforceability Issues
- Litigation in a time of scarcity.
  - optional benefits are optional
  - need for compelling stories

Shift to Managed LTSS

- Capitated Models vs. PCCMs
- LTSS historically carved-out
- Common Managed LTSS Authorities:
  - 1915(b)/(c) waivers
  - 1115 demonstration waivers

Thinking About Managed Care in LTSS

- What's the supposed managed care advantage?
  - Coordination of care for more better outcomes and less expense
  - More use of cost-effective HCBS
- What's the downside?
  - Saving money by shorting enrollees on care
- Devil's in the Details w/ MMC contracts

Long-Term Services and Supports: Beneficiary Protections in a Managed Care Environment

A toolkit for advocates on LTSS-specific beneficiary protections developed in partnership with the Disability Rights Education and Defense Fund (DREDF)

Managed Care Context | Managed Care Plan Infrastructure | HCBS Benefit Packages | Provider Choice and Access | Care Continuity | Person Centered Care Planning | Self Direction | Assessments | Care Transitions | Appeals and Grievances | Ombudsman | Meaningful Systemic Stakeholder Involvement | Civil Rights | Financing | State and Federal Oversight and Monitoring | Quality Measurements, Data and Evaluation

A growing number of states are proposing to place the responsibility for providing long-term services and supports (LTSS) to seniors and people with disabilities under managed care organizations (MCOs). These proposals offer both significant risk, and considerable opportunity. Strong beneficiary protections specific to the delivery of LTSS must be incorporated to ensure that states and MCOs develop models that best supports independence and the ability of beneficiaries to remain in or return to community settings

News for Advocates

First MOU Released — Mass. and CMS have signed the MOU

August 22 Webinar: A Critical Moment — See power point and listen to recording

LTSS Toolkit – Beneficiary Protections in a Managed Care Environment

In the News

- Care coordination demonstration achieves big government savings for dual ... McKnight's Long Term Care News
- Ohio Chooses Insurers Including Aetna, Molina to

Other Advocacy Handles

- Un-waived Medicaid statutory provisions
- ADA
  - An advocacy hurdle: Unlike HCBS Waiver application, demonstration waiver application does not demand specific answers to standard questions
    - Back and forth correspondence with CMS may provide some additional details

Service Planning

Consensus Decision?

- NY: "The person-centered plan is developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include."

Q: What If Enrollee and Team Disagree?

- Laws and contracts generally assume agreement
  - Danger that enrollee will be persuaded/coerced into going along with group decision.
    - E.g., WI Partnership Contract provides for "Purchase of Enhanced Services" for enrollee to buy service or item from MCO, if enrollee and MCO agree that service or item is "not necessary to support member outcomes"

Can Member Appeal Adverse Decision By Team?

- WI provides for notice and appeal rights.
  - Standard notice templates for adverse decisions.

WI – Appealable "Action" Includes Team Decisions

- Development of member-centered plan that is unacceptable to the member b/c
  - Requires the member to live in unacceptable place.
  - Does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes.
  - Requires care that is unnecessarily restrictive or unwanted.

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