Medicaid State Plan Options for Home and Community-Based Services

Presentation to the

Joint Commission on Health Care

Department of Medical Assistance Services

November 3, 2010

Presentation Outline

- ***Background***
- **State Plan Options for HCBS**
- **Implications for Virginia Medicaid**

Study Mandate

- House Joint Resolution No. 83 of the 2010 Virginia General Assembly requested that the Joint Legislative Audit and Review Commission study the potential costs and benefits of offering Medicaid home and community-based long-term care services (HCBS) through the State Plan for Medical Assistance
- While the resolution was tabled in sub-committee, the Virginia Department of Medical Assistance Services (DMAS) agreed to study the potential implication of providing HCBS through the State Plan

Background: Medicaid HCBS Waivers

- DMAS administers programs providing medical and long-term care services to over 900,000 Virginians
  - In 2009, DMAS provided long-term care services to over 55K individuals through home and community-based or institutional care
  - the Department spent over $1.9 billion on long-term care services (institutional + community), representing one-third of the DMAS budget
  - Virginia Medicaid is the largest payer of long-term care services in the Commonwealth (in accord with national trends)

Background: Medicaid HCBS Waivers

(continued)

- In 2009, nearly 28K individuals relied on Medicaid-funded HCBS to provide the long-term care services they need in order to remain in their homes and communities and avoid more costly institutionalization
  - In Virginia, these supportive services are provided through seven §1915(c) HCBS waiver programs:
    - HIV/AIDS Waiver
    - Developmental Disabilities and Family Supports (DD) Waiver
    - Elderly or Disabled w/ Consumer Direction (EDCD) Waiver
    - Mental Retardation / Intellectual Disabilities (MR/ID) Waiver
    - Technology Assisted (Tech) Waiver
    - Day Support Waiver
    - Alzheimer's Assisted Living Waiver

Background: Medicaid HCBS Waivers

(continued)

- Current Waiver Enrollment (as of 9/30/10)

Waiver	Enrollment	Wait List
HIV/AIDS	36	n/a
DD	576	960
EDCD	19,419	n/a
MR/ID*	8,047	5,348
Tech	359	n/a
Day Support	280	5,348**
Alzheimer's	46	0

*Dos not yet reflect 250 MR/ID slots approved 10/01/10
**Same wait list as MR/ID

Background: Medicaid HCBS Waivers

(continued)

- §1915(c) waivers require states to demonstrate cost-effectiveness as compared to a specific institutional placement (the alternate institutional placement)
  - Because of this cost-effectiveness requirement, Virginia was required to create separate waiver programs for each target population it chose to serve
- §1915(c) waivers require a rigorous submission process
  - This process includes working with numerous stakeholder groups and obtaining approval of an application that includes services covered, service delivery processes, target populations, projected utilization for each service, oversight procedures, quality management protocols, and an assessment of available providers to ensure that the provider network will adequately meet the needs of the population

Background: Medicaid HCBS Waivers

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- §1915(c) waivers must be renewed every five years through a very extensive process
  - If Virginia wishes to change one of its waiver programs between renewal periods it must re-open its application with CMS to submit the changes
    - This process is somewhat risky as CMS does not just evaluate the requested change, it re-evaluates the entire application
    - This can pose problems if CMS or Congress has recently changed requirements - CMS can require the Commonwealth to make significant changes to the waiver program, far beyond the initial change that was requested
- Individuals must qualify for institutional care (same level of need) before accessing the §1915(c) waivers

Presentation Outline

- Background
- *State Plan Options for HCBS*
- Implications for Virginia Medicaid

Provision of HCBS Through the Normal State Plan Process

- The Virginia Medicaid program is authorized under Title XIX of the Social Security Act
- In order for Virginia to receive federal funding for the Medicaid program, covered services must be approved through the Virginia State Plan for Medical Assistance
  - The State Plan serves as Virginia's contract with CMS and authorizes Virginia to receive Federal Financial Participation (FFP), also referred to as the federal "match"
- All services included in the State Plan must be available in the same amount, duration, and scope to all Medicaid recipients
  - Amendments to the State Plan are reviewed and approved by the federal Centers for Medicare and Medicaid Services (CMS)
  - Once approved, there is no scheduled renewal required

Provision of HCBS Through the Normal State Plan Process

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- Twenty-nine states offer at least one HCBS benefit through their State Plan
  - This enables individuals to receive HCBS before their needs progress to the level of qualifying them for care in a facility
- The most frequently offered HCBS through the State Plan is personal care
  - Personal care covers the cost of an attendant to go to an individual's home on a regular basis and help with activities such as bathing, dressing, and eating/feeding
  - Individuals must still qualify as having the need for this service; however, the threshold for qualifying is typically lower than the requirement for institutional care (whereas under the HCBS waivers, the needs threshold is identical to that of the alternate institutional placement)

Provision of HCBS Through the Normal State Plan Process

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- As stated earlier, if services are offered through the normal State Plan process, they must be available to all Medicaid recipients in the same amount, duration, and scope
  - States cannot target these services to specific populations, such as individuals over age 65 or those with developmental or intellectual disabilities
  - States cannot target certain conditions, such as Alzheimer's disease
  - This approach results in limited budget control

The §1915(i) State Plan Option

- The Deficit Reduction Act of 2005 (DRA) provided states a means to offer HCBS without a waiver and instead provide services through a §1915(i) State Plan Option
  - States were not allowed to cover individuals with incomes greater than 150% of the Federal Poverty Level (currently $1,354 per month for a single individual)
    - §1915(c) waivers allow for coverage up to 300% of Social Security Income (currently $2,022 per month for a single individual)
  - The DRA did not allow states to target services to specific populations under the State Plan Option
  - The DRA only allowed services specified in a §1915(c) waiver to be offered through this option

The §1915(i) State Plan Option

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- The Patient Protection and Affordable Care Act (ACA - federal health reform) modified the §1915(i) State Plan Option
  - eliminates the restriction to 150% of the Federal Poverty Level and allows states to now cover individuals up to 300% of SSI
  - eliminates the restriction in targeting services with the goal of allowing more flexibility to states to meet specific population needs
  - Allows states to request an exception to the rule allowing only services specified in the §1915(c) waiver to be offered through this option
- The §1915(i) State Plan Option is not required to be budget neutral as compared to institutional care, whereas §1915(c) waiver rules require budget neutrality

The §1915(i) State Plan Option
(continued)

- This option is essentially a hybrid of the traditional Medicaid State Plan and Medicaid waivers
- Based on recent conversations with staff from the CMS, only five states have implemented or will soon implement this option
  - the majority of these states are using the §1915(i) State Plan Option to expand behavioral health services, not to provide supportive services to seniors or individuals with disabilities
- The limited take-up on the §1915(i) Option appear to be related to remaining hurdles to the provision of HCBS through the State Plan

The §1915(i) State Plan Option
(continued)

- While the ACA significantly improved the §1915(i), there remain several barriers to this option
  - If the Department transitions a targeted group of services from a §1915(c) waiver to the §1915(i) State Plan Option, the Department could no longer require that individuals meet an institutional level of care in order to qualify for these services
    - States may establish needs-based criteria for services, but this criterion must be *less stringent* than what is required for institutional placement
  - Under the ACA, states cannot limit the number of participants that receive §1915(i) State Plan Option services
    - Currently, the enrollment of several waiver programs is capped due to budget constraints

The §1915(i) State Plan Option
(continued)

- **Barriers, continued**
  - **the §1915(i) State Plan Option application process is similar to the application process for a waiver**
  - **the State Plan Option requires a renewal by CMS every five years**
    - **CMS expects that this renewal process will be very similar to the rigorous waiver renewal process**
  - **CMS also expects that the quality oversight requirements will be similar to those of the waivers**
    - **This would mean there would be a separate oversight process for this targeted group of services than for the rest of the State Plan**

Presentation Outline

- ☐ **Background**
- ☐ **State Plan Options for HCBS**
- ■ ***Implications for Virginia Medicaid***

HCBS Coverage Under the Normal State Plan Process

- Inclusion of waiver services under the regular State Plan would have a significant fiscal impact
  - It is difficult to predict the expected utilization of a new or expanded service
  - Based on utilization experience of personal care services in states that have less restrictive functional criteria requirements than Virginia (for example requiring assistance with only two activities of daily living instead of four), utilization of personal care is typically around 15% of the Aged, Blind, and Disabled (ABD) population
  - Based on this assumption, if Virginia broadened its functional criteria, an additional 3,816 individuals would likely qualify to receive personal care. This would result in an additional expected expenditure of $92,003,495 in total funds ($46,001,747 in General Funds) each year

HCBS Coverage Under the Normal State Plan Process

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- Several states that offer State Plan personal care, such as Texas and New Mexico, however, have seen their actual expenditures for this service far exceed their initial projections
  - The number of participants in the Texas program increased 81 percent between 1999 and 2005
  - The New Mexico program found that its expenditures per participant tripled from 2000 to 2002.
- If Virginia chooses to offer personal care through its State Plan, it will want to ensure that a plan is in place to handle variances in projected demand and strong oversight and monitoring protocols exist to ensure that the program is optimally administered

HCBS Coverage Under the §1915(i) State Plan Option

- **Inclusion of waiver services under the §1915(i) State Plan Option would also appear to have a significant fiscal impact**
  - **If waivers with waiting lists (particularly the MR/ID and DD Waivers) were moved to the §1915(i) State Plan Option, the waiting lists would be eliminated under §1915(i)**
    - **Based on a 2009 study by the Department, *Plan for the Elimination of Waiting Lists under Medicaid* (RD 216, 2009), this would result in a fiscal impact of $2.4 billion in General Funds ($4.9 billion total funds) if this plan were phased in over the next decade**
  - **If the Department just transitioned the Elderly or Disabled with Consumer Direction waiver, expanded access to waiver services (resulting from a lower needs threshold for participation) would result in an estimated fiscal impact of $93,153,355 in total funds ($46,576,678 in general funds) per year**

HCBS Coverage Under the State Plan: Conclusion

- **While eliminating the obligation of obtaining HCBS wavier authority is extremely attractive, even with the amended federal requirements under the §1915(i) State Plan Option, there are significant barriers to coverage under the State Plan**
- **It is important to note that over the long-term, however, expanded and earlier utilization of support services, such as personal care, could achieve savings in hospitalizations, emergency department use, and more intensive long-term care services since injuries and physical decline might be prevented or delayed**
- **The Department will continue to stay abreast of changes and new alternatives for streamlined and cost-effective ways to administer these important services**