New Medicaid Options to Support Money Follows the Person Participants in Community-Based Housing

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To learn more about the initiative visit: http://www.neweditions.net/housing/index.asp

Introduction

State Medicaid programs across the country are undertaking significant changes to their service delivery and payment systems. Some of these changes closely align with the goals of the Money Follows the Person (MFP) program, particularly those intended to help states rebalance their long-term care systems and promote access to home and community-based services (HCBS). Efforts to rebalance expenditures and control Medicaid acute and long term care costs increasingly rely on multi-system collaborations to access mainstream housing and link Medicaid plan and waiver services to Medicaid participants moving towards and living in integrated community housing.

Major initiatives underway in many states are likely to impact MFP participants, including shifts to managed long-term care from fee-for-service systems, efforts to better coordinate physical and behavioral health care for people with chronic conditions, and state demonstrations designed to integrate care under the Medicare and Medicaid programs. These delivery system and payment reforms create new tools and service options that can support transition planning under MFP and increase access to services and supports that can help people access and maintain housing in the community. However they also represent changes to how services have been delivered (or paid for) in the past, introducing complexities that may require changes to MFP operational processes or procedures. This brief will review some of the changes underway in state Medicaid programs and the opportunities and challenges these changes present for the MFP program.

Increased Access to Home and Community-Based Services

Community First Choice Option

The Centers for Medicare and Medicaid Services (CMS) recently announced that California was the first state to receive approval of an amendment to its state Medicaid plan for the Community First

Choice Option (CFCO), which was newly created under the Affordable Care Act. Under their state plan as opposed to a waiver, the CFCO allows states to expand access to a range of community-based attendant care services and supports for Medicaid beneficiaries who would otherwise be eligible for care in an institution under their state plan as opposed to a waiver. The availability of personal care services is critical to supporting state's efforts to successfully transition individuals from institutions and to maintain residential stability in the community.

While states have long had the option to provide personal assistance services under their state Medicaid plans, the CFCO allows states to expand eligibility to people with higher incomes, permits coverage of a broader array of services and supports, and includes important participant protections in the form of quality assurance requirements. The CFCO option also allows states to propose a self-directed delivery model, allowing participants greater control over the services they receive. By allowing beneficiaries so called, "employer authority," they can hire friends, neighbors, family members, or their own trained personal care attendant to provide personal care services. Self-directed care can help address direct-care worker shortages, which has been identified by states as impeding access to HCBS for MFP participants.[1] As an incentive to states to pursue the option, states are eligible to receive a six percentage point increase in their federal medical assistance percentage (FMAP) for services provided under the option.

While California previously offered personal assistance services [referred to as In-Home Supportive Services (IHSS)], as a benefit under its state plan, the state can now receive additional federal dollars to support and expand access to personal assistance services.[2] The approval of its CFCO State Plan Amendment (SPA) will garner California an estimated $258 million dollars in federal funds in the first year of implementation, and $315 million in the second year.[3] This additional funding will help reduce the threat of budget cuts that could have impacted access to California's IHSS program for MFP participants and other elderly and disabled Medicaid beneficiaries across the state.

Services approved under California's CFCO SPA include:

- Assistance with accomplishing Activities of Daily Living or Instrumental Activities of Daily Living, and or health related tasks (e.g. bathing, dressing, basic hygiene, food shopping, laundry, etc.) through hands-on assistance, supervision, or cueing;
- Back-up systems or mechanisms to ensure continuity of services and supports;

[1] Mathmatica Policy Research. (2012). Money follows the person demonstration: Overview of state grantee progress, July to December 2011. Cambridge, MA: Author.

[2] California's FMAP is 50%. The approval of its CFCO state plan amendment will allow the state to receive a 56% federal match for services provided under the option.

[3] Gorn, D. (2012). *California first state to get funding for seniors, disabled program*. California Healthline. Sacramento, CA: California HealthCare Foundation.

- Elective training on how to select, manage, and dismiss attendants;
- Allowance for a portion of a person's service budget to go towards the purchase of restaurant meals for those who require assistance with meal preparation.

States are required to cover the first three services listed above under the CFCO, but can also include certain allowable optional services such as community transition services or costs of certain other goods and services identified in the person's plan of care.[4,5]

Alaska, Arkansas, Maryland, New York, Rhode Island, and Washington are reportedly considering pursuit of a CFCO SPA.[6] While states may be attracted to the possibility of receiving additional federal dollars to support personal care services, the fact that services under the CFCO must be provided statewide and cannot be subject to wait lists, exposes states to greater financial risks than if they offered these same types of services under a 1915(c) waiver. States are also subject to maintenance of expenditure requirement that obliges them to maintain or exceed the level of state expenditures for home and community-based attendant services for elderly or individuals with disabilities provided in the prior year for the first full fiscal year of CFCO activities, thereby limiting options for states to make fiscal changes to address any budget shortfalls. However, for states like California that already provide personal care and attendant services under their state plans, the CFCO offers states a way to receive additional federal resources to help them support and expand opportunities for individuals with disabilities to live in community-based housing.[7]

Balancing Incentive Program

While Community First Choice is a longer-term option for reducing reliance on institutions, qualifying states may also take advantage of a time-limited increase in federal financial support[8] available as part of the Balancing Incentives Program (BIP) to shift the weight of spending toward home and community-based services as opposed to institutions. Eligibility for participation in the BIP is limited to those states where less than fifty percent of its total Medicaid long-term services and supports (LTSS) expenditures for fiscal year 2009 are for non-institutionally based LTSS.[9,10] To

[4] The CFCO does not allow for coverage of services such as home modifications, assisted technology devices, or medical supplies and equipment, coverage of these types of services may be covered through other vehicles such as 1915(c) waivers or MFP.

[5] California elected not to include certain optional services that are allowable under the CFCO. However the state has indicated that these services may be covered in the future as part of its expanded vision for community-based long-term care services.

[6] Diament, Michelle. (2012). *Feds begin rollout of Community Living Program.* Disability Scoop. Retrieved on September 6, 2012 from: http://www.disabilityscoop.com/2012/09/05/feds-rollout-community-living/16385/

[7] As of October 2010, approximately 31 states covered personal assistance services under their state plan, with coverage limitations on the frequency or intensity of the service varying by state. A searchable database of Medicaid benefits is located at: http://medicaidbenefits.kff.org

[8] Increased federal funding is available from October 1, 2011 to September 30, 2015 or until the full $3 billion allocated for the BIP has been committed.

[9] Only five states: Oregon, New Mexico, Washington, Arkansas, and California direct 50% or more of their LTSS to HCBS.

[10] Kaiser Family Foundation. (2010). Medicaid long-term services and supports: Key changes in the health reform law. Washington, DC: Author.

take advantage of this increase, qualifying states must make certain required structural changes that promote increased utilization of home and community-based services including:

- Creating a "no wrong door single point of entry system" that: promotes a streamlined way for consumers to obtain information about the availability of home and community-based services and how to apply for such services; assists with referrals for home and community-based supports and services; and allows for both financial and clinical eligibility determinations.
- Developing "conflict-free" case management services to work with eligible individuals to create an individualized service plan and to arrange for services and supports identified in the service plan, and perform ongoing monitoring and follow-up activities to assure services are being delivered as outlined in the service plan. Conflict-free case management for this purpose ensures that there is no conflict of interest between the case manager and those staff providing the services in the individualized service plan.
- Implementing a statewide, uniform, core standardized assessment for determining eligibility for non-institutional services.

To date, eight states (Georgia, Indiana, Iowa, Maryland, Mississippi, Missouri, New Hampshire, and Texas) have received approval from CMS of their BIP applications making them eligible for between $26 million (in New Hampshire) and $301 million (in Texas) in federal matching funds.

There is a natural alignment between the MFP and BIP programs. MFP administrative funds can be used to support the development of some of the structural changes required under the BIP[11] such as developing a data system to collect the core standardized assessment data, or training staff.[12] The MFP program is also an important aspect of a state's BIP plan as it can help states meet their goals of increased spending on community-based long-term services and supports.[13]

The availability of additional federal dollars under the BIP will assist states to further the goals and objectives of their MFP programs through infrastructure enhancements and improved access to HCBS. For example, in addition to the required structural changes described above, Georgia plans to use the enhanced FMAP available under the BIP to expand the number of slots in its five 1915(c) waiver programs and develop three new community-based mental health services for people with serious mental illness.

[11] Subject to CMS approval

[12] Mission Analytics Group and Human Services Research Institute. (2011). The Balancing Incentive Program and Money Follows the Person: A Natural Partnership. Webinar conducted on behalf of the Centers for Medicare and Medicaid Services. Retrieved on October 18, 2012 from: http://www.balancingincentiveprogram.org/

[13] Following the 365 day transition period, the enhanced FMAP available under the BIP can be claimed for individuals transitioned under the MFP program, thus helping states meet their BIP community-based LTSS spending requirement.

Improved Care Coordination

Health Homes for Individuals with Chronic Conditions

The Affordable Care Act provides states the option through a SPA to provide for health homes for enrollees with chronic conditions. Chronic conditions could include mental health and substance use disorders, diabetes, asthma, heart disease, HIV/AIDS, obesity, or other conditions proposed by states and approved by the federal government. Eligibility for participation in this is limited to those Medicaid eligible individuals who:

- Have at least two chronic conditions; or
- One chronic condition and are at risk of having a second chronic condition; or
- One serious and persistent mental health condition.

People enrolled in 1915(c) waiver programs as well as those who are dually eligible for Medicare and Medicaid cannot be excluded from participation if they otherwise meet the established health home eligibility criteria. This would include individuals who have moved out of institutions as part of the MFP program and are now receiving long-term care services in the community.

Specific health home services provided for through this option include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transition care, including appropriate follow-up from inpatient to other settings;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology to link services as feasible and appropriate.

The definition of who qualifies as a provider under this provision extends beyond primary care physicians to include community mental health centers, home health agencies, and teams of health care professionals, such as physicians and social workers or other behavioral health professionals, who work together to coordinate care.

Given the complex physical and behavioral health needs of MFP participants, this option offers the opportunity to access comprehensive health care that is coordinated across providers and promotes integration of physical and behavioral health. Seven states (Iowa, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island) have received CMS approval of their health home SPAs and another two states (Alabama and Wisconsin) are awaiting CMS approval.

States are still in the early stages of implementing their health home programs, but should consider how health homes can be used to help support eligible MFP participants to receive comprehensive coordinated physical and behavioral health services to support them in community-based housing, thereby reducing their risk of re-institutionalization. In Missouri for example, a person with a developmental disability and another qualifying

chronic condition (e.g. asthma, diabetes, etc.) is eligible to participate in its Primary Care Health Home program. For individuals transitioning to the community from qualified settings under the state's MFP program, enrollment in a Primary Care Health Home could become part of a person's community transition plan.

Comprehensive care management and care coordination services are important components of the health home model. Given that MFP participants will have access to some type of care coordination through the MFP program, managed care, a 1915(c) waiver, or other Medicaid state plan service, it will be important to clarify roles and responsibilities to ensure that services are not duplicated and that people receive the level of coordination appropriate to meet their needs. The intensity of the care coordination services offered through a health home will vary. Some states have designed it with low staff-to-patient ratios while other states have high staff-to-patient ratios. It will be important to assess as part of the transition planning process whether the intensity of the care coordination service offered through the Health Home will meet the needs of the MFP participant.

Also, some states may have more than one health home program. For example, Missouri has one health home program specifically designed for people with mental health or substance use issues and another for people with chronic physical health problems, such as asthma, diabetes, heart disease, a developmental disability, etc. Understanding exactly what type and level of services are offered through the health home will be important to ensure that MFP participants have access to the appropriate supports to help them live successfully at home and in the community.[14]

Managed Long-Term Care and Dual Demonstration Projects

States are increasingly turning to managed long-term care services and supports programs to help them control costs, coordinate care, and provide greater budget certainty. California, Delaware, Florida, Kansas, New Jersey, New Mexico, New York, and Texas and have either recently implemented a managed long-term care program or have proposed to do through other means.[15,16] It is anticipated that by 2014, 26 states will have a managed long-term services and supports programs in place.[17]

Managed long-term care aligns well with MFP in that managed care organizations (MCOs) are typically motivated to help people remain in the community and avoid costly institutional placements. This is because MCOs are paid a set fee by the Medicaid program per enrollee per month and are financially at-risk if incurred costs exceed payments. This same financial arrangement also

[14] A state's health home SPA will contain details about eligibility criteria, how referrals will occur, and health home provider types. Copies of approved health home SPAs are located at: http://www.integratedcareresourcecenter.com/hhstateresources.aspx.

[15] Some states are implementing managed long-term services and supports through Medicaid Section 1115 research and demonstration authority

[16] Kaiser Family Foundation. (2012). An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity. Washington, D.C.: Author.

[17] Saucier, P., Kasten, J., Burwell, B., Gold, L. (2012). The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 update. Truven Health Analytics.

creates the incentive for some MCOs to limit or restrict access to services to control costs. However, with proper quality monitoring procedures and contract provisions designed to protect consumers, managed care can be an ally to MFP by promoting access to services to help people avoid institutional care. For example, some states have used managed care savings to expand existing supports and services to serve more people or to develop new and innovative community-based services.

Given that many MFP participants are dually eligible for Medicaid and Medicare,[18] the new Duals Demonstration projects have the potential to impact the MFP program. With different rules, regulations, data, provider, and payment systems, coordinating care between Medicare and Medicaid is particularly challenging, leaving consumers (and providers) struggling to navigate the two complex systems. Also, because Medicaid pays for long-term care and Medicare for acute hospital care, there is little incentive for the Medicaid program to undertake initiatives in their long-term care programs that might help people avoid use of emergency rooms or inpatient hospital services. This is because any savings resulting from such an initiative would benefit the Medicare program. The lack of financial alignment between the two programs only serves to contribute to the disproportionately high health care costs among this population (dual eligibles comprise about 15 percent of the Medicaid population but account for almost 40 percent of Medicaid costs; in the Medicare program they are about 21 percent of the population but account for 36 percent of costs).[19]

The Duals Demonstration projects seek to correct some of these long-standing issues by aligning the financial incentives between Medicare and Medicaid and integrating primary, acute, mental health/substance use and long-term care services for the dually eligible population. Massachusetts was the first state to receive CMS approval of its project. Under its demonstration, dual eligible adults between the ages of 21 and 64 will be served by Integrated Care Organizations that will be responsible for delivery of Medicare and Medicaid services. A unique feature of the Massachusetts demonstration is the requirement that these organizations contract with community-based organizations to provide independent LTSS coordination to help promote access to a broad range of supports and services that can assist the dual eligible population to live independently in the community.[20]

Managed long-term care services and supports programs and Duals Demonstration projects are

[18] To be eligible for MFP, participants must have met Medicaid eligibility criteria and many are eligible for Medicare based on age or because they have qualified for Medicare due to a long-term disability.

[19] Kaiser Commission on Medicaid and the Uninsured, (2012). The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare. Washington, DC: Author.

[20] The extent to which this model will impact Massachusetts' MFP program is likely to be limited. This is because individuals receiving 1915(c) waiver services are not currently eligible for enrollment in the demonstration, though some dual eligible MFP participants who have transitioned to the community and are not enrolled in a waiver may be eligible for enrollment. The state has indicated however that enrollment of 1915(c) waiver participants in the demonstration may occur in the future.

intended to streamline access to supports and services, ease service and system navigation, improve quality, and reduce health care costs. These are positive program features that could serve to ease transitions out of institutions for MFP participants and help people avoid re-institutionalization. A series of policy briefs developed by the Kaiser Commission on Medicaid and the Uninsured, highlighted issues requiring attention as states move more seniors and people with disabilities into managed care products.[21,22,23] These issues include:

- Development and expansion of existing managed care provider networks to include providers that possess the specialized skills and competencies necessary to address the complex medical and social issues of people with serious and long-term disabilities.
- Given that people with special healthcare needs have long-standing relationships with their care providers, creation of policies that limit disruptions in care or treatment to promote continuity of care must be a priority.
- Enrollment and marketing materials and outreach strategies must take into consideration the unique (and diverse) needs of this population including those with cognitive limitations or dementia, people experiencing homelessness, or those with serious mental health or substance use issues. Use of peer enrollment specialists, large-print media, independent enrollment brokers, stationing of health plan customer service representatives at shelters, and use of a managed care Ombudsman are among a few of the strategies that could be employed to help people navigate the managed care enrollment process.
- Meaningful inclusion and involvement of consumers in the development of a managed LTSS program or dual demonstration is necessary to ensure that the program is designed in a way that meets their needs. Including consumers on advisory boards, paying them to participate in focus groups, or hiring them as consultants to assist in the program design, will help build trust and is critical to "getting it right." It is also important to consider that a 'one size fits all approach' to the design and implementation of a managed long-term care program is not likely to be effective given the diversity of the population.
- Attention to how long-term care services, primary care, behavioral health, and acute care services (e.g. emergency, inpatient hospital), are integrated is important to making sure that these services are well coordinated and to help reduce some of the problems with cost-shifting that can occur when an MCO is only responsible for a limited array of services. In states with separate delivery systems for mental health or substance use systems and long-term care, managed care contracts should contain provisions detailing

[21] Kaiser Commission on Medicaid and the Uninsured, (2012). Current and Emerging Issues in Medicaid Risk-Based Managed Care: Insights From an Expert Roundtable. Washington, DC: Author.

[22] Kaiser Commission on Medicaid and the Uninsured. (2012). *People with Disabilities and Medicaid Managed care: Key issues to consider.* Washington, DC: Author.

[23] Kaiser Commission on Medicaid and the Uninsured. (2012). Examining Medicaid Managed Long-Term Service and Support Programs: Key issues to consider. Washington, DC: Author.

how the systems will work together to coordinate care, including specific information related to data-sharing.

If done thoughtfully, there is great potential for managed long-term care programs and the Duals Demonstrations to help states meet their MFP transition goals, offering new tools and resources to help facilitate transitions and help people be successful at home and in the community. While the traditional fee-for-service Medicaid program is constrained by federal regulations that may stymie innovation, states can develop managed care contracts that align with the goals of the MFP program and promote community-living. States such as Delaware, Hawaii, New Mexico, North Carolina, and Texas already include MFP or MFP-like services in their managed LTSS programs.[24] This trend is likely to continue as more states move toward managed long-term care and work to ensure compliance with the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision.

Housing and Services Connections

Access to safe, affordable housing in the community is a cornerstone of successful efforts under MFP to assist people to move from institutional to community settings. The same is true for the Community First Choice, Balancing Incentives, Health Home, Dual Demonstrations and LTSS managed care initiatives described above: affordable housing is crucial to the success of community integration and long term care rebalancing efforts. Efforts to rebalance expenditures and control Medicaid acute and long term care costs increasingly rely on multi-system collaborations to access mainstream housing and link Medicaid plan and waiver services to Medicaid participants moving towards and living in integrated community housing. In addition, states wishing to avoid the use of non-integrated settings under the Americans with Disabilities Act, and states already implementing *Olmstead* settlement agreements or court orders, are envisioning the same types of housing and service linkage strategies as are the MFP and LTSS initiatives.

MFP programs have developed strategies at state and local levels to improve housing opportunities for people with disabilities as they leave institutions and reenter the community. These strategies, and the service linkages that have been developed to make community living successful, can be equally useful to people with disabilities served through the other Medicaid and Medicare initiatives mentioned above. The housing and service linkage strategies can also make it possible to reduce hospitalization and emergency department costs as well as institutional and LTSS expenditures. The expertise already developed by MFP Program Directors, Housing Coordinators, and other MFP staff can be helpful to Medicaid agencies as they design and implement their rebalancing and cost containment efforts.

[24] Saucier, P., Kasten, J., Burwell, B., Gold, L. (2012). The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 update. Truven Health Analytics.

State Medicaid agencies are becoming more attuned to the connection between housing and health outcomes, and are in many cases are developing state level linkages with housing finance agencies and other sources of affordable integrated housing. The fact that 35 states and the District of Columbia applied for funding available as part of the Department of Housing and Urban Development's new Section 811 Project Rental Assistance Demonstration, that assists the lowest income people with significant and long-term disabilities to live independently in the community by providing affordable housing linked with voluntary services and supports, is a testament to this increasing awareness of the need for housing linked with services. The companion issue brief to this paper, entitled: "***Strategies for Creating Integrated Supportive Housing for People with Disabilities***", provides additional information and case studies of use to MFP programs as they seek to increase housing opportunities for people with disabilities.

Conclusion

As states work to take advantage of the opportunities within the Affordable Care Act intended to help rebalance their long-term care systems, control health care costs, and improve quality, MFP programs will gain access to new tools and resources that can help them transition people into community-based housing and avoid re-institutionalization. Learning about the changes underway in your state will help MFP Project Directors anticipate how these changes could impact the MFP program and allow for the opportunity to make necessary adjustments in the state's MFP Operational Protocol. As states embark on long-term care delivery system changes, MFP Project Directors should be engaged early to help inform and shape these initiatives given their experience in navigating multiple complex systems and ensuring that people have the housing, supports and services necessary to live successfully in the community.

This brief was prepared by Kelly English of the Technical Assistance Collaborative.
Editorial assistance was provided by Emily Cooper, Steve Day, Kevin Martone, and Jenny Chan. For additional information and related resources, visit www.tacinc.org.