



NATIONAL ACADEMY for STATE HEALTH POLICY

January 2006

Deficit Reduction Omnibus Reconciliation Act Conference Committee Report Offers States New Options on Home and Community Based Services

Deficit Reduction Omnibus Reconciliation Act of 2005¹

As written, the Deficit Reduction Omnibus Reconciliation Act of 2005 authorizes two new home and community-based services (HCBS) initiatives. Effective January 1, 2007, states will be able to submit a state plan amendment to cover home and community based services (HCBS). This new option will offer the flexibility of a 1915 (c) waiver and the benefits of using the state plan. The second initiative authorizes a Money Follows the Person Demonstration Grant Program that will provide states with an enhanced match for services for up to 12 months for individuals who move from an inpatient setting to a qualified community residence.

Other provisions of the bill change the definition of and coverage for targeted case management, modify asset transfer requirements, expand the public-private Long-Term Care Insurance Partnership Program, and clarify elements of self-directed cash and counseling programs. This brief summarizes the most significant aspects of the two new HCBS initiatives.

HCBS Medicaid State Plan Option²

Eligibility and level of care

The conference agreement allows states for the first time to offer home and community-based services under the state plan but with the flexibility available in 1915 (c) waivers. Under the agreement, states would be able to serve individuals with incomes below 150 percent of the Federal poverty level. However, the agreement also allows states flexibility to set income and resource requirements that should allow coverage of people currently served under 1915 (c) waivers with incomes up to 300 percent of SSI³ \$1735 in 2005).

Managing enrollment

Under the agreement, states would submit to the Centers for Medicare & Medicaid Services (CMS) an estimate of the number of individuals who will be served through HCBS. States will be allowed to modify the level-of-care criteria if enrollment exceeds the estimate by giving the public and CMS 60 days notice. Individuals already enrolled in HCBS who no longer meet the criteria would continue to be served for 12 months from the initial date of service.

However, the conference agreement does not include a waiver of comparability, and this may result in a conflict with a current provision that allows states to limit how many beneficiaries may be served. Comparability requires that services available to any individual in the categorically needy group or a covered medically needy group must be equal in amount, duration, and scope for all recipients within the same group.⁴

The agreement separates the tie between HCBS and nursing home level of care. Under the agreement, HCBS eligible individuals do not have to meet the level-of-care criteria for admission to a nursing home, a hospital, or an ICF-MR. States will be able to establish needs-based criteria for these services that may take into account an individual's inability to perform two or more activities of daily living (ADLs) as defined in the IRS code⁵; the need for significant assistance in performing ADLs; or other risk factors identified by the state. At the same time, states must establish level-of-care criteria for nursing home, hospital, and ICF-MR⁶ admission that are higher than the criteria used for the HCBS state plan program.

Assessment process

Under the agreement, states will need to conduct an independent evaluation and assessment of HCBS applicants to determine an individual's functional eligibility, determine the necessary level of services and supports needed based on the individual's physical and mental capacity, prevent unnecessary or inappropriate care, and establish an individualized care plan. The assessment will need to be done face-to-face and, when appropriate, include consultation with family members, guardians or representatives, and health care professionals involved in the applicant's care. The assessment will also need to include a review of the applicant's ability to self-direct his or her services.

Presumptive eligibility

States will be allowed to presume eligibility for up to 60 days for the independent evaluation, assessment, and HCBS services received. This presumptive eligibility would not extend to other Medicaid services.

Quality assurance

States will have to ensure that home and community-based services meet federal and state guidelines for quality assurance and include safeguards against conflicts of interest in the independent evaluation and assessment. The agreement directs the Agency for Healthcare Research and Quality to develop program performance indicators, client function indicators, and satisfaction measures.

Flexibility

The agreement allows states to implement the program on a less than statewide basis and to set income and resource rules that differ from other rules applicable in the community. States that use the new option to offer HCBS through the state plan will also be able to continue similar efforts under Section 1915 (c) or 1115 waivers.

Money Follows the Person Demonstration Program

The agreement appropriates funds for the Money Follows the Person Demonstration Program proposed by the Administration earlier this year. The conference committee made some changes in the bill that passed the Senate. Grants may be made beginning January 2007 rather than 2009, and provisions for enhanced federal reimbursement were clarified.

The agreement allows grants to states to pay for home and community-based services, including transition services, for up to 12 months for people who move from an inpatient facility (nursing home, hospital, ICF-MR) to a “qualified residence.” To qualify for services, an individual must have resided in the inpatient facility for at least six months but not more than two years and must receive Medicaid benefits.

The agreement defines a qualified residence as a home that is owned or leased by the individual or family member, an apartment with an individual lease, or a residence in a community-based residential setting in which no more than four unrelated individuals reside. Apartment-style assisted living units would not qualify.

Applications

States interested in participating in the demonstration program will need to submit applications that include:

- An assurance of a public process to design, develop, and evaluate the project;
- Connection to a qualified HCBS program to assure continuation of services for individuals after 12 months of service coverage;
- A description of the service area;
- A description of the groups of individuals to be served;
- The number of individuals in each group who will be served; and
- The total annual qualified expenditures for each year of the project.

Balancing

To participate in the program, a state will also have to describe how it will balance its long-term care spending. States will need to submit data on institutional and HCBS expenditures in the fiscal year prior to the demonstration and to specify the methods that will be used to increase both the actual expenditures for HCBS and the percentage of spending for those services. The application will also need to describe how the state will eliminate legal, budgetary, and other barriers to supporting individuals in the setting of their choice.

The agreement also requires of states a maintenance of effort. Total HCBS expenditures during the demonstration must be greater than the highest of what was spent in FY 2005 or in any subsequent fiscal year prior to the demonstration.

Funding

The agreement appropriates \$250 million for the demonstration program for the nine months of FY 2007 (January to September), \$300 million for FY 2008; \$350 million for FY 2009; \$400 million for FY 2010; and \$450 million for FY 2011.

The conference report changes the state matching requirement included in the Senate bill. Under the agreement, grantees will receive an enhanced Federal Medicaid Assistance Percentage (FMAP) that is equal to one half of the difference between the regular matching rate and 100 percent. However, the matching rate can not exceed 90 percent. For instance, a state whose FMAP is 60 percent would receive 80 percent reimbursement for 12 months for services to individuals who moved to a qualified residence.

Each quarter, the state would be paid from its grant award the lesser of the enhanced FMAP for the qualified expenditures or the amount remaining in the grant. If expenditures exceed the amount of the grant, grantees may claim reimbursement using the regular FMAP.

Other requirements

Under the agreement, state programs must operate for at least two consecutive years during the five-year demonstration period. State proposals must include a quality assurance plan and may include an option for self-directed services. Funding is included for technical assistance and oversight for states seeking to upgrade their quality assurance and improvement systems.

Notes

¹ In late December, 2005, the Senate made changes in the conference report that must now be approved by the House when it returns from its recess early in 2006.

² The bill contains many of the recommendations included in a report by the National Academy for State Health Policy, *Making Medicaid Work for the 21st Century*. For further information about the report and testimony before the Senate Finance Committee by Alan Weil, go to http://www.nashp.org/_docdisp_page.cfm?LID=0D5298D4-E308-40D6-B0CE7C85E0A5C959.

³ Supplemental Security Income.

⁴ 42 CFR 440.240 (b).

⁵ These include bathing, dressing, eating, transferring, toileting, and continence.

⁶ Intermediate care facility for the mentally retarded.

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