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A Challenge for States: Assuring Timely Access to Optimal Long-Term Services and Supports in the Community

Executive Summary

The Medicaid program is a major payer for long-term services and supports (LTSS) in the United States, accounting for 40 percent of total spending for long-term services and supports. The federal government has played an active role in sponsoring initiatives to promote a shift to community-based care; and evidence from several states suggests that providing care in the community can be less expensive than providing institutional care. The Affordable Care Act (ACA) provides incentives for states to implement certain policies and practices that have proven effective at promoting access to long-term services and supports in the community. States' experience has shown that operational details can have a significant impact on whether plans to provide more services and supports in the community succeed. This brief highlights two important aspects of operations in states that affect access to LTSS in the community: efforts to provide accurate and timely information to consumers, and procedures to make Medicaid eligibility determinations quickly and efficiently.

Key Findings

- **Single entry point agencies, such as Aging and Disability Resource Centers (ADRCs), and "no wrong door" approaches are most effective when consumers receive complete and accurate information at the first point of contact.** The ACA provides additional funding to expand ADRCs. New Hampshire has established ADRCs in every county and requires each to use standard packets of information developed by the state. Systems that provide complete information about options and that require affirmative choices among options on the part of consumers, as in New Jersey, are likely to provide more community-based services.
- **A key component of getting information to consumers is ensuring that information is available on a statewide basis, while also maintaining up to date information about local resources.** This can be achieved by obtaining information about local resources or by routing calls to local assistors, such that even if there is only one statewide telephone number for people to call, the callers can have access to locally relevant information. In Minnesota, a data management organization sends regular correspondence to state and local staff to confirm what information has changed each month and update the central system.
- **Improving eligibility systems is one of the most important practical steps states can take to assure that consumers who wish to remain the community are able to do so.** Coordinating Medicaid financial and functional eligibility determinations is a key element of optimizing access to LTSS. States such as Washington and Oregon that have a single administrative agency for all LTSS are better able to coordinate eligibility determinations. The ability to make eligibility determinations quickly is an essential operational detail that can affect the practical choices consumers have. Therefore, states are developing "fast track" systems.
- **In addition to providing consumers with information it is also important for states to provide comprehensive assistance to enable consumers to use the information effectively**. The distinction between providing information and providing assistance is an important one. There are some administrative advantages to the use of telephone lines and websites for consumer support, but to be most effective, the opportunity for individual assistance or counseling should be available. Accommodations for consumers whose first language is not English are an important feature of assistance efforts.

Innovations in states to better inform consumers about the LTSS options available to them and to conduct eligibility determinations in a timely and efficient manner are key operational elements associated with increasing the use of community based services and supports. In the current economic climate states may not be able to make major changes to their LTSS systems, but they can consider administrative changes to improve access to services and to provide consumers with more meaningful choices.

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A CHALLENGE FOR STATES: ASSURING TIMELY ACCESS TO OPTIMAL LONG-TERM SERVICES AND SUPPORTS IN THE COMMUNITY

INTRODUCTION

The Medicaid program, jointly financed and administered by states and the federal government, is a major payer for long-term services and supports in the United States, accounting for 40 percent of total spending for long-term services and supports.[i] Almost 4 million people rely on Medicaid long-term services and supports, 1 million nursing home residents and 2.8 million community-based residents.[ii] All state Medicaid programs are required to pay for institutional care, but most community-based care is provided at state option. The trend is toward more community-based care. In 2009, approximately 45 percent of Medicaid LTSS spending was for home and community-based services, up from 24 percent in 1997.[iii] Reasons for the change are preferences on the part of consumers and interest on the part of states in using limited resources in the most cost-effective manner. Evidence from states indicates that providing care in the community can be less expensive than providing institutional care.[iv] The federal government has also played an active role since the mid-1990s in sponsoring initiatives to promote a shift to community-based care.

States have a variety of options for making community-based long-term services and supports available under Medicaid (see Appendix). The Affordable Care Act[v] (ACA) provides incentives to encourage states to expand and adopt certain policies and practices that, based on experience to date, have come to be regarded as important in making high quality long-term services and supports available in the community. The legislative requirements reflect recognition on the part of lawmakers that operational details can have a significant impact on whether plans to provide more services and supports in the community succeed.

This issue brief examines two particularly important aspects of operations in states that affect access to services and supports in the community: efforts to provide consumers with information about options so they can make choices; and procedures to make Medicaid eligibility determinations quickly and efficiently. The brief draws on the professional literature as well as on interviews with officials in states engaged in planning or activities related to these issues.

Given significant budget cuts and financial uncertainty, states have not been able to make as much progress recently as they had anticipated in developing community-based long-term service and support systems, and with fewer resources, states have had to curtail some helpful practices. But state officials continue to consider options for program change. The Affordable Care Act includes provisions to help improve access. In September 2010, the Department of Health and Human Services announced $68 million in grants, made possible by the ACA, to help consumers understand and choose amount their health and long-term care options. The ACA also established the *State Balancing Incentive Payments Program.* The program will provide enhanced federal matching payments to eligible states that make certain operational changes, including changes to provide consumers with information about community-based options. Eighteen states report that they have decided to apply or are considering an application for the program; others may consider it when more guidance is available from CMS.[vi] Even if states are not able or are not inclined to make major system changes, adopting some of the policies and procedures described in this brief can increase access to existing community-based LTSS.

INFORMATION ABOUT OPTIONS FOR CONSUMERS

For consumers who need publicly financed long-term services and supports, the logical first step is to learn about the available options. All states have institutional and community-based options, at least for some populations, but consumers' ability to make choices can be affected by factors such as where they seek information, how complete the information they receive is, whether they are asked to choose, and whether counseling or assistance in making choices is available to them.

Provide information about all options regardless of where consumers inquire

The *State Balancing Incentive Payments Program* established by the Affordable Care Act includes a requirement for the establishment of statewide "No Wrong Door/Single Entry Point" systems. The legislation states that the systems would "enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal…" The idea is to ensure that complete information will be available regardless of how or where consumers inquire. Thus, consumers can obtain information in the manner that is most convenient and comfortable for them.

A "no wrong door" approach can be effective, provided that the first point of contact in any setting provides complete and accurate information about the array of available services and supports and the eligibility requirements associated with each, and presents the information in an unbiased manner. Traditionally this has not occurred and practically it is difficult to achieve given the number of options that may be available. Officials in some states say that currently, if the first inquiry is to a nursing facility, consumers may not learn about community-based options.

"Single entry point" agencies are intended to be one-stop information sources. This concept is familiar to states, which have been developing *Aging and Disability Resource Centers (ADRCs)* since 2003 when grants to establish centers to streamline access to long-term services and supports were first available. The Affordable Care Act provides additional funding to expand *Aging and Disability Resource Centers*, $10 million per year for five years beginning in 2010. Features of ADRCs such as the way they are organized, the functions they perform, the populations they serve, and whether they are available locally or statewide vary from state to state and have an impact on how effective the ADRCs or similar entities can be.

Assess current activity in states

This is a logical time, with additional federal funds available for ADRCs and with several years of experience across states, to assess the breadth, utility, and quality of information and counseling activities in states and to develop standards. As of October 2010, 325 ADRC sites operate in 45 states and territories, with tremendous variation among the sites. The FY 2010 ADRC grant announcement included requirements for states to begin to develop standards related to activities such as counseling, staff training, and client tracking. A federal evaluation of the ADRC program is also planned.[vii] For now, all states should consider adopting certain practices, such as those described below, to improve information and assistance for consumers seeking LTSS at ADRCs and elsewhere.

Ensure that information is available on a statewide basis

In the fall of 2009, ADRCs were operating in 49 states, but only 27 reported that that the centers were operating statewide.[viii] The term "statewide" is used to describe different circumstances such as offices

across the state where consumers receive help in person or telephone or web-based information sources that are available to anyone in the state. The requirement for statewide systems associated with the *State Balancing Incentive Payments Program,* the availability of additional ADRC funding, and new emphasis on standards to accompany funding may lead some states to enhance their statewide systems and others to develop statewide systems.

Currently, ADRCs are active in 7 of 21 counties in **New Jersey**. The goal is to have them operating statewide by the end of 2011. The appeal of a statewide system is that regardless of where they live, consumers have access to information. One challenge is to assure that consistent information is available across the state. **New Hampshire** has established 13 ADRCs, called *Service Link Resource Centers (SLRC)*, located in every county in the state. All of the *SLRCs* are required to use standard packets of information developed by the state, which contain information about LTSS options, forms to apply for Medicaid community-based services and supports, a list of documents needed for verification, and a description of the application process. **Wisconsin** has developed templates for materials that the ADRCs use in the counseling process. The ADRCs may add relevant information about their own services and about local services and supports, but the goal is to help ensure that information is presented in a similar manner across the state, particularly that all options for services and supports are given equal weight when enrollment counselors present information to consumers.

An important consideration in establishing statewide systems is to have information about local resources available. Local input is essential when web-based systems are used, not only when the system is established, but also on an ongoing basis to keep information current. Similarly, assistance provided by telephone must be based on information that is locally pertinent and up to date. This can be achieved by obtaining input about local resources or by routing calls to local assistors. The *Senior Linkage Line* is a well established information source in **Minnesota**. It works closely with the *Disability Linkage Line* for younger adults with disabilities. Although there is just one telephone number statewide, calls are routed, based on the area code for the originating call, to local Area Agencies on Aging. Thus, specific information about local services and supports is available. The program also uses several methods to ensure that information used by the *Linkage Line* as well as in the web-based *MinnesotaHealth.info* tool is current. A data management organization based at an Area Agency on Aging keeps the system up to date. Data managers send an email to state and local staff to show what information has been changed each month. Also, providers have access to parts of the system so that they can change descriptive information about their services. Similarly, *Linkage Line* state and local staff work with the data management organization to make additions or changes when they learn of new services or supports or discover that information in the system is not accurate.

Require that consumers choose among options

Systems that require consumer choice are likely to provide more community-based services and supports. This can be achieved in a number of ways. In **New Jersey**, for example, regardless of how or where they inquire, consumers must first be determined financially and functionally eligible for Medicaid. Then *Community Choice* counselors present information about institutional or different types of community-based options; consumers make a choice at that point in the process. In **Vermont's** *Choices for Care* program, long-term clinical coordinators, nurses employed by the state, conduct initial assessments to determine a consumer's clinical eligibility for the nursing home level of care. Consumers who qualify functionally and financially then have the opportunity to choose between nursing home and community-based services. Consumers in the "highest need" group are entitled to receive services

immediately; those who are considered "high need" are entitled to the extent that funding is available to serve them.

In an effort to streamline the process and promote choice, **New Hampshire** had required that consumers wishing to apply for services be referred to long-term services counselors at the *Service Link Resource Centers.* Nurses employed by the state were located at each SLRC where they assessed all consumers who applied for long-term services and supports. Budgetary constraints and challenges filling vacant nursing positions led to a change in the system, however. Now, only consumers seeking community-based care enter through the SLRC. Those who are discharged from a hospital to a nursing facility or who choose to enter a nursing facility may directly enter nursing facilities where professionals employed by the facilities conduct assessments. Thus, it is quite possible that a consumer could apply and be approved for nursing facility services without knowing about community-based options.

Like New Hampshire, **Arkansas** does not have the resources to provide screening and counseling for everyone seeking long-term services and supports. The state made a practical decision to have case managers employed by nursing facilities conduct functional assessments for institutional care and assessment nurses employed by the Division of Aging conduct assessments for community-based care. The state's single ADRC is available statewide, but currently just serve people who inquire. The goal is to make ADRCs the single entry point for everyone seeking community-based care.

Provide comprehensive assistance

One operational feature that can affect the extent to which consumers choose community-based services is whether counseling is available. The distinction between providing information and providing assistance is an important one. There are advantages, including administrative efficiencies, associated with the development of websites or telephone hotlines that anyone in the state can use. To be most effective, however, the opportunity for individual counseling or assistance should be available. For some consumers, the opportunity to have face-to-face counseling is particularly important.

In **Iowa's** pilot *Options Counseling* program, about half of counseling services are provided in person, one-third by phone, and the remainder using methods such as e-mail, mail, or fax. **Minnesota** has systems for providing information and assistance that are more sophisticated than those used in most other states. Information is available in four ways: through printed materials, web sites, telephone, and in person in some places. One feature of particular interest is the *MinnesotaHealth.info* website's "chat" capacity. As a practical matter, this allows counselors at Area Agencies on Aging, ADRCs, some county offices, and on the *Senior Linkage Line* to communicate quickly with state staff and with each other. Counselors can send a policy question to staff via chat and get an answer while they are counseling a consumer. Consumers can access the chat directly for immediate live support.

Make accommodations for consumers whose first language is not English

The need to provide information and assistance for consumers with limited English proficiency is well recognized, but not always achieved. Ideally, information about long-term services and supports is available in printed or web-based formats in several languages and consumers have the opportunity to talk with someone who can provide information in the appropriate language. Given the complexity of the topic and limited resources in states, this is not easy to accomplish, but some states have made progress.

Washington makes applications for services and supports available in twelve languages. The state collects data on clients' primary languages; more than 35 languages have been identified among consumers seeking or using services. Agreements with organizations such as the Asian Counseling and Referring Service enhance the state's ability to respond to consumers who prefer to receive information in a language other than English. Washington also works with case management entities that cater to consumers of particular cultures. State contracts require that case management agencies have licensed interpreters available. In **Minnesota**, programs are required to include a standard "language block" on all printed materials, which advises consumers, in ten languages, that they can contact a language line if they would like to speak to someone in any of the languages. The *Senior Linkage Line* and all of the Area Agencies on Aging in the state have agreements with the language line and therefore have the capacity to bring translators into the conversation when they are needed. **Wisconsin** requires, in contracts with the ADRCs, that they have the capacity to communicate with consumers in their native languages. Most fulfill this requirement by subscribing to a telephone-based translation service. Also, some care management organizations in Wisconsin contract with community-based organizations that serve as care management units for particular populations. In Milwaukee, for example, there are units that work primarily with the Hispanic, Hmong, and Russian populations.

Help with a broad range of programs

Entry points can be most effective if they take a broad perspective on the types of information that may be useful to consumers seeking information about LTSS. For example, two programs that provide financial assistance for low-income Medicare beneficiaries have low take-up rates. They are the Medicare Savings Programs, which assist with Medicare Part B premium payments and cost sharing, and the Medicare Part D Low-Income Subsidy, which provides premium and cost-sharing assistance for drug coverage. Efforts to make information about eligibility requirements for these and other assistance programs a routine part of counseling for consumers seeking information about LTSS could help low-income consumers obtain valuable related benefits.

MEDICAID ELIGIBILITY ASSESSMENTS

The administrative function of making eligibility determinations is often ignored when states develop plans to promote community-bases long-term services and supports, but improving the eligibility system is one of the most important practical steps states can take to assure that consumers who wish to remain in the community are able to do so. No matter how much information states provide for consumers or how carefully they design community-based service and support programs, efforts to keep people in the community will be thwarted when consumers need to arrange assistance quickly, but eligibility assessments are cumbersome or lengthy. Timely decisions are particularly important in the case of elderly consumers who often need immediate services following an unexpected hospitalization.

Consumers must meet financial and functional eligibility requirements to qualify for Medicaid long-term services and supports. For the elderly and people with disabilities who need LTSS, the income eligibility limits are often tied to the Supplemental Security Income Program - $674 per month in 2010 – but states may set higher income limits. Assets, which are also examined to determine financial eligibility for Medicaid LTSS, are limited to $2,000 for an individual and $3,00 for a couple in most states.[ix] Each state Medicaid program establishes criteria for the type and level or severity of functional limitations or needs that a consumer must have to qualify for various types of long-term services and supports.

Coordinate Medicaid functional and financial eligibility determinations

In most states, Medicaid financial and functional eligibility are determined by different government agencies. Mandates from state officials with jurisdiction over all of the agencies involved can be helpful in promoting collaboration to develop more efficient eligibility systems. States that have a single administrative agency for all LTSS are better able to coordinate eligibility determinations. Efforts to promote coordination have the potential to increase administrative efficiency as well as shorten the eligibility process.

Washington is the best example of a state that not only consolidated long-term service and support programs under a single administrative agency, but also makes Medicaid financial eligibility determinations within the LTSS system. Thus, consumers can apply for financial and functional eligibility determinations through their local Home and Community Services offices. The co-location of functional and financial assessment workers is very helpful in that they view themselves as a team and there is more opportunity for formal and informal interaction. Eligibility determinations for programs such as the Medicare Savings Programs, food assistance, and cash grants can also occur in the HCS office.

Oregon also coordinates eligibility determinations. Local offices throughout the state make eligibility determinations for long-term services and supports. The majority of the offices are operated by the state Senior and People with Disability Division. Area Agencies on Aging, sponsored by local governments, operate the offices in four districts. Each of the offices makes both financial and functional eligibility determinations. In some instances, eligibility workers and case managers respectively make the determinations. In others, case managers perform both types of evaluation. The state has obtained permission from CMS to have case managers serve in the capacity of making eligibility determinations for Medicaid.

States that do not have a single agency or do not co-locate personnel, have tried other approaches to foster coordination. **Arkansas** is developing an electronic system that will include a single assessment tool as well as the capacity to track the status of applications. With permission, copies of correspondence sent to consumers can also be sent to advocates who will then be able to assist clients more effectively. More immediately, Arkansas plans to hire 20 HCBS counselors who will function as eligibility facilitators and options counselors and operate across the state. One of their most important roles will be to get applicants through the eligibility process. The counselors will use a team approach and consult on behalf of applicants with both the assessment nurses who make functional eligibility determinations and the county offices that determine financial eligibility. They will also help manage the process for redetermining eligibility when necessary.

Vermont has made modest changes to better coordinate between the agencies that perform the functional and financial eligibility determinations. Now, a single application may be submitted to either agency and receipt of the application at one agency triggers action on the part of the other. Previously, the activities occurred sequentially; a functional screen was completed first and then consumers were advised to apply to Medicaid for a financial eligibility determination.

Make "fast-track" financial eligibility determinations

The ability to make eligibility determinations quickly is a key operational detail that can affect the practical choices consumers have. If the eligibility determination process is lengthy, people who want to remain in the community rather than go to institutions may not be able to arrange for the services and

supports they need while they are waiting for assurance that they will have Medicaid coverage. Traditionally, institutions have been more willing than community-based providers to provide services before Medicaid eligibility is definitively established. Institutions are often seen as the only safe immediate alternative unless states can perform fast eligibility determinations. States have tried a variety of strategies to try to make financial eligibility determinations for LTSS more quickly. Most are in the pilot stages or are used for a small well-defined population, however.

New Jersey has established a "fast track" system that allows Office on Aging workers to consult low-income and PAAD (*Pharmaceutical Assistance to the Aged and Disabled*) program databases to verify financial information. This process takes one or two days and then tentative approval is available while the eligibility is confirmed. In **Pennsylvania's** *Community Choice* pilot program, assessors employed by Area Agencies on Aging are on call at all times and in 24 hours, if necessary, can not only develop an interim service plan, but also can collect basic information about an individual's financial circumstances. Dedicated fax lines are used to get the information to Medicaid quickly and facilitate quick preliminary financial eligibility determinations. In **Washington,** applicants whose financial circumstances are not complex can make self-declarations about their finances and receive long-term services and supports in advance of the financial eligibility determination if a case manager thinks they will be found eligible. They are required to complete a full application for Medicaid within 10 days and the services may be provided for up to 90 days.

Arizona has a waiver to use their own pre-admission screening assessment to make functional eligibility determinations in lieu of having to wait for the Disability determination Services Administration to make an SSI disability determination for applicants for long-term services and supports financed by Medicaid. Also, the use of a computerized interactive application has shortened the application process for LTSS somewhat. Formerly, when people called to inquire about LTSS they received an 8-page paper form and state eligibility workers got involved once the application was returned. Now, in response to an inquiry, an eligibility worker can start the application on the computer while talking with the person. Eligibility workers' ability to communicate with applicants and their families by telephone and by email has also been helpful.

Assure payment for services provided during the "fast track" period

Some states are wary of making temporary or conditional eligibility determinations for community-based care or they do so on a very limited basis because Medicaid will not pay for services provided in the interim period if the consumer ultimately is not eligible for Medicaid. States have addressed this issue in different ways, but the result in all cases is that fast track eligibility is used in relatively few cases.

New Jersey and **Pennsylvania** ask consumers to sign forms indicating that they are aware that they will be financially responsible if Medicaid does not pay. This policy protects the state but discourages some consumers. The number of people using the fast track system is not large. The need for payment has rarely occurred. In **Washington**, consumers are not asked to sign forms indicating that they will be financially responsible. As a matter of policy, the state will cover costs if necessary, but this happens infrequently. In all states, efforts to conduct eligibility reviews more quickly and thus shorten the assessment period could minimize the financial risk for states and consumers.

Make uniform functional eligibility determinations

The requirement in the Affordable Care Act's *State Balancing Incentive Payments Program* for states to develop core standardized assessment instruments addresses another operational detail that can affect consumers' access to community-based services. The use of uniform assessments for all applicants is associated with systems that provide more meaningful choice for consumers.[x] States that use the same standards and practices to make functional eligibility determinations regardless of whether the consumer seeks institutional or community-based services even the playing field and promote choice for consumers.

The trend in states is to develop standard electronic assessment instruments that can be used to assess all consumers who apply for LTSS. Some initial investment is required to purchase equipment and develop systems, but the use of electronic systems can reduce redundancy if core information is collected only once rather than at several points. The systems can facilitate communication among program staff and can be used to achieve continuity for consumers. Many of the functions associated with LTSS programs can be accomplished more efficiently and effectively.

Washington, New Jersey, and Minnesota have all developed tools that are not disability or program-specific. **Washington**'s *CARE (Comprehensive Assessment Reporting and Evaluation)* instrument is the most comprehensive in terms of the functional, health-related, social, and environmental topics covered. It also includes elements for financial eligibility documentation. The fully automated instrument is used not only for assessment, but also employs an algorithm that can be used to develop a plan of care and for monitoring service quality. **Minnesota's** *MNCHOICE* is an electronic tool that is structured to ask for basic information from all applicants followed by questions that are appropriate to each applicant's circumstances. Certified assessors will use the tool with individuals seeking public or private assistance with long-term services and supports. The tool is in development with the goal of having it in use statewide by July 2011.

Provide assistance with applications

Having staff on site who can initiate the Medicaid application process or make eligibility determinations can be particularly effective in helping consumers obtain LTSS services. In response to a survey, 12 ADRCs reported that Medicaid financial eligibility staff are available on site at least on a part-time basis. Functional eligibility determinations also are performed by ADRCs. Some 17 ADRCs reported that they conduct functional eligibility determinations for home and community based services and 13 said that they make functional eligibility determinations for nursing facility services. ADRCs also help by tracking the status of applications as they move through the system. Nine ADRCs reported that they can track Medicaid eligibility status electronically and three more reported that Medicaid routinely advises them of consumers' eligibility status.[xi] Providing assistance with applications is an important function for more states to consider as they plan for ADRC expansions.

Counselors at **New Hampshire's** SLRCs help consumers apply for benefits, using secure web-based applications. They also track the progress of applications and work with state officials if necessary. They have intervened with banks on behalf of consumers to ask that bank fees be waived when applications are stalled because consumers cannot pay for several years of bank statements that are required for verification purposes. Face-to-face interviews are required as part of the financial eligibility determination for Medicaid in New Hampshire. Division of Family Assistance Family Service Specialists are available at SLRCs on scheduled days and times at least once a week and work as part of the SLRC

team. In addition, the state has trained Long-Term Support Counselors located at the SLRCs to conduct face-to-face interviews if timely appointments are not available from the Division of Family Assistance. In **New Jersey**, county income maintenance workers are located at the ADRCs on a regular basis, but not daily.

Each ADRC in **Wisconsin** employs information and assistance specialists who are knowledgeable about the Medicaid application process and financial eligibility rules and who assist consumers. In addition, each ADRC employs at least one elderly benefits specialist and one disability benefits specialist to help with more complicated situations. Their mission is to be sure that consumers get the full array of benefits for which they are eligible. They receive training from and can consult with attorneys who are under contract to advocacy groups to provide back-up when eligibility and enrollment issues arise. The counselors also have close relationships with the county income maintenance offices and "read-only" access to the state's income maintenance data base so that they can track the progress of applications.

CONCLUSION

Innovations in states to better inform consumers about the LTSS options available to them and to conduct eligibility determinations in a timely, objective, and consistent manner are key operational elements associated with increasing the use of community-based services and supports.

The Affordable Care Act includes additional funding for *Aging and Disability Resource Centers*. The Act also requires that states choosing to participate in the *State Balancing Incentive Payments Program* make information and assistance available on a statewide basis. To achieve a better balance between institutional and community based services, all states should make information about all options available to consumers on a statewide basis. An additional requirement that consumers make affirmative choices about the type of services and supports they prefer will help ensure that they are well informed about options. Accommodations for consumers who need individual counseling or information and assistance in a language other than English are also needed in some cases to assure access to optimal services and supports.

Choices for long-term services and supports are only meaningful if access to the services is assured. A quick eligibility process with coordinated financial and functional assessments is a crucial component of a system that promotes community-based LTSS. The use of standard assessment instruments, as required in the Affordable Care Act for the *State Balancing Incentive Payments Program*, is another key operational detail that helps promote choice for consumers.

Changes in practice are most easily accomplished in states where all long term services and supports are administered by a single agency. The use of electronic systems can also have a positive effect on the way LTSS programs operate, increasing states' ability not only to streamline the application process and make uniform assessments, but also to develop care plans and monitor the delivery of services. In the current economic environment, states may not be equipped to expand or make major changes to their LTSS systems, but they can consider administrative changes to improve access to services and to provide consumers with more meaningful choices.

APPENDIX: OPTIONS FOR COMMUNITY-BASED LONG-TERM SERVICES AND SUPPORTS FINANCED BY MEDICAID

State Medicaid programs are required to cover services provided by nursing facilities, but there is no single community-based LTSS benefit covered by the Medicaid program. Instead, a variety of services, programs, and initiatives – almost all optional for states – are offered. States have considerable leeway in defining the type and amount of services and supports that are available as well as establishing who qualifies for each benefit. As a result, the mix of services differs across states. States can offer community-based LTSS as state plan services, waiver services, or as part of special initiatives.

Three types of benefits account for almost all community-based LTSS. In 2009, home health services, personal care, and waiver services accounted for 9, 23, and 66 percent of Medicaid home and community-based service expenditures respectively. Other funding authorities, such as the PCE program or demonstration projects accounted for the remaining spending.[xii]

Home health services: a mandatory state plan service that includes nursing or home health services and medical supplies, equipment, and appliances.

Personal care services: an optional state plan service, help people perform activities that they normally would perform themselves if they did not have a disability or a chronic condition. The services must be offered statewide.

Waivers: allow states to waive certain requirements associated with the Medicaid program to target specific population groups, limit geographic areas, services, and the number of participants, and provide services that are not otherwise covered by Medicaid. Home and community-based service waivers, or 1915(c) waivers, allow states to provide long-term care services in a community-based setting to individuals who otherwise would require institutional services reimbursable by Medicaid. States must specify the population served, the available services, and must ensure that the cost of care under the waiver is no higher than the cost of institutional care. Some states also provide LTSS under 1115 research and demonstration waivers.

Other options for Medicaid coverage of community-based LTSS are more recently available to states:

The 1915(i) home and community based state plan option established in the 2005 Deficit Reduction Act (DRA) has been available to states since January 2007, but only a small number of states use it. Under the option, individuals do not have to qualify for an institutional level of care to be eligible for community-based services. The ACA allows states to broaden the eligibility criteria. As of October 2010, benefits must be available statewide and states cannot place caps on enrollment, but services may be targeted to specific populations.

The Community First Choice Option, established by the ACA, creates a new state plan option effective October 2011, that covers a broad range of services and supports including benefits such as one month's rent, utility deposits, or household furnishings, for Medicaid-eligible consumers who require an institutional level of care. The income eligibility criteria for the benefit are comparable to the criteria for institutional care. States with approved programs must cover all eligible consumers. Unlike waiver services, there is no budget neutrality requirement for this option. States that adopt this option will receive an additional six

percentage points above their Medicaid federal matching percentage (FMAP) for expenditures related to the option for five years.

Since the mid-1990's, the federal government has sponsored initiatives to shift Medicaid spending from institutional to community-based care and to enhance consumers' roles in choosing and managing services and supports. Many of the current initiatives have evolved from activities associated with the New Freedom Initiative, which was established in 2001 to remove barriers to community living.

Consumer directed or self-directed services give individuals or their surrogates the authority to determine what services they need, to make arrangements for the services and to manage the services within a budget. Several federal initiatives have been used to promote consumer direction. Beginning in 1998, the Cash and Counseling demonstration tested the concept. Subsequently, consumer direction was included as part of some CMS Systems Change grants. States may include a consumer-directed service option in their HCBS waiver programs. Also, the DA of 2005 established a Medicaid state plan option for self-direction of personal assistance services – section 1915(j).

Money Follows the Person, established in 2007, awards grants to states to help residents of institutions make a transition to the community. States provide a range of services including transition, housing, and technological assistance and receive an enhanced federal match rate (75-90% FMAP) for a 12-month period for all LTS costs for each person who successfully transitions to the community. The ACA extends the demonstration through 2016 and reduces the institutional length of stay needed to qualify for benefits.

The State Balancing Incentive Program, part of the ACA, will provide enhanced federal matching payments to eligible states that make specified structural program changes, effective October 1, 2011: establish a statewide system of single entry points for LTSS; adopt certain case management practices; and develop and use standard assessment tools in a uniform manner across the state.

This issue brief was prepared by Laura Summer of Georgetown Health Policy Institute and Jhamirah Howard of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

[i] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Long-Term Care Services and Supports*, February 2009.
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[iii] Eiken, S., K. Sredl, B. Burwell, L. Gold, *Medicaid Long-Term Care Expenditures in FY2009*, Thomson Reuters, August 2010.
[iv] Kaye, S., M. LaPlante, C. Harrington, "Do Non-institutional Long-Term Care Services Reduce Medicaid Spending?" Health Affairs 28, no 1, January/February 2009.
[v] The Affordable Care Act (ACA) refers to the Patient Protection and Affordable Care Act, P.L. 111-148, enacted March 23, 2010, together with the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, enacted March 30, 2010.
[vi] Smith, V., K. Gifford, E. Ellis, R. Rudowitz, L. Snyder, *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured, September 2010.
[vii] O'Shaughnessy, C., *Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze*, National Health Policy Forum, November 2010.
[viii] National Association of State Units on Aging, State of Aging: 2009 Perspectives on State Units on Aging Policies and Practices, October 2009.
[ix] Thirty-six states, including DC, allow the "medically needy" – those with high medical bills – to spend down to an eligibility standard set by the state.
[x] Summer, L., *Community-based long-term services financed by Medicaid: Managing resources to provide appropriate Medicaid services*, Long-Term Care Financing Project, Georgetown University, June 2007.
[xi] Alecxih, L., *Streamlining Access to Public Benefits*, Aging and Disability Resource Center Technical Assistance Exchange, available at: http//www.adrc-tae.org, added August 6, 2009.
[xii] Eiken et al, August 2010.

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