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# Strengthening the Aging Network Issue Brief

*The Affordable Care Act: New Option for  
Providing Long-Term Services and Supports*

# The Affordable Care Act: Long-Term Services and Supports in the States

The Affordable Care Act of 2010 (ACA) offers a number of options and financial incentives for states seeking to expand their systems of long-term services and supports (LTSS). Many of these opportunities can be leveraged to work together and to build on existing initiatives. The result can be a strengthened infrastructure for service provision and an LTSS system that can better meet the needs of Medicaid beneficiaries. Key provisions of the ACA are summarized below, followed by considerations for states seeking to take advantage of these new opportunities.

## **Community First Choice Option**

Section 2401 of the ACA authorizes, effective October 1, 2011, a new Medicaid state plan option for providing community-based attendant services to Medicaid participants called the Community First Choice (CFC) option. States adopting this optional state plan benefit will receive a 6 percent increase in the Federal Medical Assistance Percentage (FMAP) for these services indefinitely.

Two groups of Medicaid beneficiaries are eligible to receive attendant care services under CFC: those with incomes up to 150 percent of the Federal Poverty Level (FPL) and those with incomes greater than 150 percent of the FPL who have been determined to require an institutional level of care. Depending on the state's eligibility rules, this could be up to 300 percent of the SSI Federal Benefit Rate.

States must offer CFC statewide. Services must include not only attendant care for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), but also backup systems such as personal emergency response systems and voluntary training for participants on how to hire and manage attendants. States have the option of covering certain transition costs and items that increase independence or substitute for human assistance. Home modifications are excluded.

States are required to conduct a face-to-face assessment of functional need at least annually and base the service plan on this assessment. CMS is developing universal core elements that they will expect assessment tools to include.

States may choose an agency model for attendant care services or a self-directed model with a financial management entity performing payroll and bill-paying functions for the participant. States have the option of disbursing cash prospectively to participants or issuing vouchers.

States must provide data to CMS on individuals receiving CFC services by type of disability, age, gender, education level, and employment status. Reporting on performance and quality of care measures will be required as well.

The proposed rules include a “maintenance of effort” requirement. For the first 12 months of CFC implementation, the state’s share of Medicaid expenditures for personal care attendant services for individuals with disabilities or elderly individuals must remain at the same level or be greater than expenditures in the previous year.

### **Considerations for States**

As an optional state plan benefit, CFC will be an entitlement – that is, any individual who is eligible for Medicaid and meets any eligibility requirements specific to CFC participation is entitled to the benefit. In addition, a state cannot place a ceiling on the number of people who may enroll in CFC and the service must be offered statewide.

Thirty-two states already provide personal care as an optional Medicaid state plan benefit. In 2007, these states provided optional state plan personal care services to 826,251 individuals at a cost of \$9.5 billion. Personal care and attendant care are also common waiver services. In recent years, a number of states have seen expenditures for personal care and attendant care spiral out of control and are searching for ways to rein in costs. The CFC option is viewed as a potential means for accomplishing this.

States pondering the pros and cons of the CFC option should consider the following:

1. Can CFC be structured to replace the state’s existing personal care and attendant care offerings both in the state plan and in waivers? Or is adoption of CFC likely to significantly expand eligibility for personal/attendant care services? States should compare current eligibility requirements with eligibility requirements for CFC to determine if any new populations would become eligible for attendant care under CFC. There is also likely to be a “woodwork effect” from individuals

enrolling in Medicaid for the first time in order to receive the new attendant care benefits.

2. Can states impose stricter eligibility for CFC than what is stated in the Affordable Care Act and CMS's proposed rules? For example, the proposed rules state that any Medicaid participant with income up to 150 percent of the FPL is eligible for CFC. Can states restrict eligibility such that only those who have been determined to require an institutional level of care are eligible? States should seek clarification from CMS on whether states can impose more restrictive eligibility rules.
3. What are the implications for waivers that provide personal care and/or attendant care? In order to qualify for the additional 6 percent FMAP, attendant care must be provided through the CFC option in the state plan. States would be wise to amend their waivers to remove personal care and attendant care services as waiver services and have waiver participants receive attendant care through CFC. States should consider removing waiver transition services and emergency response systems as well if these services are similar to what will be offered under CFC.
4. Is the state prepared to comply with the requirements for self-directed service models? For example, the proposed rules require the use of a financial management entity, a person-centered plan of service based on the assessment, a service budget based on the plan of care, a support system encompassing participant rights information and how to use a self-directed service model, and training for providers.
5. Will the additional 6 percent FMAP cover the cost of additional services that the state must provide under CFC? The additional quality assurance and reporting requirements? If the state does not anticipate at least breaking even, the state may want to reconsider whether to implement CFC. In addition to attendant care to assist participants with ADLs and IADLs, states are required to provide back-up systems or mechanisms to ensure continuity of services and supports (e.g., personal emergency response systems, pagers), as well as voluntary training for participants in hiring and managing attendants. Optional services that states may offer include certain transition costs and expenditures for certain items that promote independence or substitute for human assistance. States should seek clarification from CMS on whether there will be any guidelines or requirements on how the additional 6 percent FMAP must be spent.
6. Does the state currently use a universal assessment tool or have plans to implement one in the near future? CFC requires a face-to-face assessment of functional need and a service plan based on this assessment. CMS does not anticipate prescribing a particular assessment tool, but the proposed rules state that

the assessment should include “information about the individual’s health condition, personal goals and preferences for the provision of services, identified functional limitations, age, school participation status, employment, household, and other factors ...” Furthermore, CMS is “currently working to determine universal core elements to include in a standard assessment for consistency across programs” and states will be expected to adopt them. Unless the state is committed to implementing a comprehensive, universal assessment tool that can be used across different programs, the state will not be able to comply with CFC requirements – or the requirements of a number of other provisions in the ACA.

7. Does the state have an active network of stakeholders who would be willing serve on a Development and Implementation Council? The proposed rules stress the importance of robust stakeholder input and collaboration.

8. Can the state’s information systems support CFC quality assurance and data collection requirements, or will system reengineering be required? CMS proposes that states implement performance measures to assess provision of attendant care services, quality of care measures examining individual outcomes (e.g., functional indicators, participant satisfaction), standards for consumer training on self-directed delivery models, and procedures for appeals. States will be required to submit data to the federal government on utilization and costs of CFC services and the number of individuals served by type of disability, age, gender, education level, and employment status.

9. Is the current cost of personal/attendant care services in the state unsustainable? If so, the state should consider “rebasings” personal/attendant care services in order to lower its cost structure for one year prior to implementing CFC. This way the state would have a lower maintenance of effort requirement. The proposed CFC rules state that during the first 12 months of CFC implementation, the state’s share of Medicaid expenditures for personal care attendant services must remain at the same level or be greater than expenditures during the previous year. Lowering the cost structure could involve limiting eligibility for personal care services, reengineering the assessment process to ensure that the number of allowable hours of personal care is consistent with assessed need, placing a weekly or monthly cap on the number of allowable personal care hours, or reducing provider rates.

### **State Balancing Incentive Payments Program**

The State Balancing Incentive Payments Program (SBIP) in Section 10202 of the ACA goes into effect October 1, 2011. States meeting certain rebalancing targets will receive an increased FMAP during the four-year period October 1, 2011, to September 30, 2015. States spending less than 25 percent of LTSS expenditures for

community-based services will receive a 5 percent increase in FMAP and be expected to reach a target of 25 percent of expenditures for community-based services by October 1, 2015. States with 25 percent to 50 percent of LTSS expenditures for community-based services will receive a 2 percent increase in FMAP and be required to reach 50 percent of expenditures for community-based services by October 1, 2015.

The legislation is silent on sanctions for states who do not meet the rebalancing targets. Participating states will have data collection requirements and must implement a single-point-of-entry system for accessing LTSS, conflict-free case management services, and a core standardized assessment tool. In addition, participating states may not impose stricter eligibility standards than were in place on December 31, 2010. CMS expects to issue guidance and an application for states in mid-2011.

### **Considerations for States**

Rebalancing is a slow process as evidenced by state Medicaid data analyzed annually by Thomson Reuters. Nationally, over the past decade the rate of spending on home and community-based services (HCBS) as a percentage of total Medicaid spending for LTSS has increased at a rate of 1 percent to 3 percent per year. Examining the most recent four years of data to see what might be reasonable to achieve during the ACA's four-year "balancing incentive period" (2011-2015) can be informative to states considering participating in the SBIP program. In 2005, 38 percent of total Medicaid spending for LTSS in the United States was for HCBS. In 2009, the percentage increased to 45 percent, an increase of 7 percentage points over four years.

Eligibility for the SBIP program will depend on CMS's rules for calculating the percentage of Medicaid LTSS expenditures for community-based services. Eligible states may or may not be those who would appear to be eligible in the Thomson Reuters reports. However, using the 2009 Thomson Reuters data as a benchmark, 39 states would be eligible for SBIP – 37 states had HCBS expenditures of more than 25 percent but less than 50 percent of total Medicaid LTSS spending and 2 states had HCBS expenditures of 25 percent or less.

Thomson Reuters also breaks down the state rankings for Medicaid spending on HCBS into two populations: a) elderly people aged 65 and older and adults with physical disabilities and b) individuals with developmental disabilities. States have had far greater success in rebalancing spending for individuals with developmental disabilities. In 2009, only 6 states had HCBS expenditures less than 50 percent of total Medicaid LTSS spending for the population with developmental disabilities. However, states fare much worse in the rankings for elderly people and adults with

physical disabilities. If CMS were to issue eligibility rules similar to the definition used by Thomson Reuters for this group, 46 states would potentially be eligible for the SBIP program: 24 states in the “above 25 percent but less than 50 percent” category and 21 states in the “25 percent or less” category.

The pace of rebalancing can be influenced by what stage in the “rebalancing life cycle” a state is in. More “mature” states with well developed systems of community-based services and supports may find it more difficult to achieve continued large gains in rebalancing. In contrast, “less mature” states may be able to achieve significant gains by ramping up the availability of community-based services through HCBS waiver expansion.

Another consideration for states is that rebalancing towards more community-based care does not always involve overall cost savings. A recent study found that expanding Medicaid HCBS typically results in a short-term increase in spending, followed by a decline in institutional spending and long-term cost savings. And states with limited non-institutional services experienced greater spending growth than states with more expansive community-based LTSS. Furthermore, unless the number of nursing home residents is reduced – which often requires reducing the number of licensed nursing home beds to eliminate “backfill” – states cannot achieve savings in institutional costs.

In determining whether to apply to the SBIP program, states should ask the following questions:

1. Is the state eligible for the SBIP program? Eligibility criteria are being developed by CMS, so it is not yet clear which states will qualify for the program.
2. Can the state meet the aggressive rebalancing targets? According to the ACA, states must achieve, within four years, rebalancing targets of either 25 percent or 50 percent of Medicaid LTSS spending for HCBS. Is this feasible given that nationally, an increase of 1 percent to 3 percent per year has been the norm over the past decade? A state at 15 percent would have to see an increase of 10 percentage points in four years to meet the 25 percent target. In contrast, a state at 23 percent would only have to achieve an increase of 2 percentage points to meet the 50 percent target. For many states, meeting the rebalancing targets will require major HCBS program expansions, which in turn will require careful planning, skilled execution, and explicit year-by-year goals.
3. What sanctions will be imposed on states that do not meet the rebalancing targets by 2015? Must the additional FMAP be returned? Will CMS establish interim benchmarks that states must meet? Once again, guidance is needed on this issue.



4. Will the increased FMAP cover the cost of any HCBS program expansions? Data collection requirements and additional required services? States will be required to collect CMS-prescribed data for quality and outcomes measures – including measures on beneficiary satisfaction and experience with providers – as well as beneficiary-level data on HCBS services provided. States must also have a single-point-of-entry system, provide conflict free case management, and use a qualifying assessment tool. The state shouldn't consider applying for SBIP unless the state expects to at least break even with the additional FMAP. States should also look for guidance from CMS on whether there will be any requirements for how the additional FMAP may be spent.
5. Can the state comply with the maintenance of effort requirement? States may not impose more restrictive eligibility standards, methodologies, or procedures for non-institutional LTSS than what was in effect on December 31, 2010.
6. Does the state currently use a universal assessment tool or have plans to implement one in the near future? It is likely that CMS's requirement for a "core standard assessment instrument" will be similar or identical to the requirements for a universal assessment tool in the proposed rules for CFC (see CFC Question 6 above).
7. Does the state currently have an established system of Aging and Disability Resource Centers (ADRCs) or some other single-point-of-entry system? This is a requirement for SBIP, so applications from states with well established, statewide systems are likely to be given preference.
8. What is "conflict free" case management and can the state comply with this requirement? There is no definition for conflict free case management, so states should watch for guidance on this.

#### **1915(i) State Plan Amendment**

The Deficit Reduction Act (DRA) of 2005 amended Section 1915 of the Social Security Act by adding subsection (i) to enable states to offer home and community-based services as a state plan benefit. However, only five states adopted the 1915(i) state plan benefit, so Section 2402 of the ACA makes further amendments in an attempt to encourage more states to consider this option. States may now include individuals with incomes up to 300 percent of the SSI Federal Benefit Rate who would be eligible for a HCBS waiver. In addition, states can target benefits to individuals with selected conditions. For example, states could target Medicaid



beneficiaries with specified mental health conditions. However, states must now offer the benefit statewide and there can be no ceiling on the number of individuals receiving the benefit. Initial approval and subsequent renewals for this new state plan option are for five-year periods. States may offer more than one 1915(i) benefit package, targeting different groups of beneficiaries.

The changes to 1915(i) became effective October 1, 2010. CMS issued guidance on August 6, 2010, in a letter to state Medicaid directors.

### **Considerations for States**

The 1915(i) could be an effective means for providing specialized community-based supports to populations who might otherwise find it difficult to remain in the community or transition back to the community after a nursing home stay. Some states are considering the 1915(i) for persons with serious mental health conditions that require specialized services and supports. States may offer all of the services permissible under a 1915(c) HCBS waiver. In addition, for persons with chronic mental illness, states may offer day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services. States also have the option to propose other services to CMS.

States contemplating a 1915(i) state plan amendment should consider these questions:

1. What population(s) could benefit most from a 1915(i) state plan amendment? In addition to individuals with mental health conditions, are there groups now being served by waivers who could be more efficiently and effectively served by the 1915(i)?
2. Can the target population be defined using clear non-financial needs-based criteria? Otherwise, there is likely to be eligibility “creep” and the state may have difficulty projecting and controlling the number of people eligible for 1915(i) services.
3. What is the benefit package? Are specialized services for the target population evidence-based? Will the 1915(i) be cost-effective? How do the services complement other Medicaid services available to beneficiaries?

### **Money Follows the Person Demonstration**

Section 2403 of the ACA extends the Money Follows the Person (MFP) demonstration to 2016, with appropriations totaling \$2.25 billion for FYs 2012-2016. Fourteen new states and territories were approved as MFP Demonstration sites in February 2011, bringing the total number of MFP sites to 43 (CHECK). MFP is

intended to strengthen the ability of states to transition individuals from institutions, eliminate barriers that prevent Medicaid beneficiaries from receiving LTSS in the setting of their choice, ensure the availability of quality community-based services, and assist states in rebalancing. States receive an enhanced FMAP (referred to as MFP “savings”) for qualifying home and community-based services for individuals who meet MFP eligibility requirements and transition to a qualifying residence in the community. With financial incentives for information technology (IT) and infrastructure development and the availability of funding for specialized staff and training, MFP is being positioned by many states as a centerpiece of rebalancing efforts.

### **Considerations for States**

MFP Demonstration states should be sure to address the following questions:

1. Can MFP be positioned as a focal point of the state’s rebalancing efforts? What are the potential advantages to this? Enhanced service coordination for beneficiaries? Greater coordination and cooperation across agencies? A mechanism for strategic investment in the LTSS system and infrastructure?
2. How can MFP “savings” be strategically invested to further develop the state’s LTSS system? To enroll more people in waivers? To develop new services or train new providers? To develop IT infrastructure to facilitate claims processing, waiver tracking, case management, performance monitoring, quality assurance, and/or reporting? To develop the type of universal assessment tool required by a number of the provisions in the ACA?

### **Health Homes**

Section 2703 of the ACA permits states to provide a “health home” to Medicaid beneficiaries with at least two chronic conditions under a new state plan option. The health home provider will be responsible for coordinating all of the individual’s care. This new option became available to states on January 1, 2011. The FMAP for health home services will be 90 percent for the first two years that the state plan amendment is in effect. Recognizing that a new service such as this will require planning and development of a new payment methodology, the federal government is encouraging requests from states to spend up to \$500,000 in Medicaid funding at the state’s regular FMAP to finance planning activities.

The ACA defines chronic conditions to include asthma, diabetes, heart disease, a mental health condition, a substance use disorder, or being overweight with a body mass index of over 25. The Secretary of the U.S. Department of Health and Human Services (DHHS) has the authority to expand this list of conditions. States can target populations based on the number of chronic conditions, a specified combination of

chronic conditions, or the severity of the chronic conditions. Because “comparability” is waived, states may provide health home services in a different amount, duration, and/or scope than the state offers to other populations.

The health home’s function is to coordinate, not provide, an array of services that treat the whole person, including physical health, mental health, and substance abuse prevention and treatment services. Only six core health home services specified in the ACA are reimbursed at the 90 percent FMAP. All other services provided to the specified population are reimbursed at the state’s regular FMAP.

### **Considerations for States**

Health homes represent an unparalleled opportunity for innovation in the delivery and financing of services for Medicaid participants with complex and expensive needs. The Center for Medicare and Medicaid Innovation (CMMI) is prepared to provide technical assistance to states seeking to pursue this new state plan option. Questions for states include the following:

1. What populations could benefit most from health homes? Can these populations be clearly defined? Could high-cost waiver participants be transitioned to a health home? Participants with mental health conditions coupled with other chronic conditions? Unless eligibility criteria are clear, the state is likely to find more people than anticipated are eligible. There is also likely to be a “woodwork effect” from people not previously enrolled in Medicaid.
2. Will the target population include individuals eligible for both Medicare and Medicaid (“dual eligibles”)? States may not exclude dual eligibles because participation in the health home cannot be limited by eligibility category. Coordinating the Medicare and Medicaid funding streams presents a particular challenge. In addition, most any savings realized from reduced hospitalizations or acute care services would be realized by Medicare and not Medicaid. States should consider obtaining Medicare data for dual eligibles to facilitate monitoring utilization across the two programs.
3. Will the 90 percent FMAP over two years cover the cost of the program? How will the program be sustained over the long term? While states may apply to spend up to \$500,000 in Medicaid funding at the regular FMAP for program development, there may be additional service costs for the target population and CMS requires states to collect program data and participate in the national evaluation. Can efficiencies in service delivery be achieved over time so that the program can be sustained?

4. Is the health home model the state intends to implement evidence-based? Are providers available and willing to participate? States have considerable flexibility in choosing a health home model. States are advised to select a model that has been tested and evaluated. Many states have existing models that could potentially be adapted to meet ACA requirements. Linkages to LTSS, primary care, and behavioral health services may be required.

5. What kind of payment model does the state envision? Does the state have experience with managed care payment systems and encounter data? Per-member-per-month and risk-based capitated payment methodologies are likely to be encouraged by CMS. Payment methods can be “tiered” based on severity of the condition. If a capitated payment method is used, the state will have to be able to distinguish the services eligible for the 90 percent FMAP.

6. Can the state’s information systems support data collection and evaluation requirements? The ACA requires an interim survey of states and an independent evaluation, as well as reports to Congress. States will be required to calculate cost savings and collect data such as avoidable hospital re-admissions, emergency room visits, and skilled nursing facility admissions. Providers of home health services must also report on quality measures.

### **Community Living Assistance Services and Supports (CLASS)**

CLASS is a federally administered, voluntary insurance program that will be available to all Americans and financed through contributions from participating individuals. Individuals will pay premiums through payroll deductions in exchange for a cash benefit in the event of disability. Employees of employers who agree to participate in premium withholding will automatically be enrolled in the program, but may opt-out at any time. Individuals employed by non-participating employers will be able to make premium payments under alternative arrangements.

An individual can qualify for a cash benefit if he or she has paid premiums for a minimum of five years, has a disability expected to last for at least 90 days, and meets functional and/or cognitive eligibility criteria established by the DHHS Secretary. The average benefit is expected to begin at about \$50 per day, adjusted for inflation in future years. Cash benefits may be used to purchase nonmedical services and supports that enable the beneficiary to maintain independence at home or in a community-based setting. For Medicaid beneficiaries, a portion of the benefit is to be applied towards the individual’s institutional care or community-based LTSS services.

The ACA does not designate an effective date for CLASS. Regulations are expected from DHHS in November 2012; actual start-up could come as soon as 2013.

In December 2010, the National Commission on Fiscal Responsibility and Reform recommended that CLASS be reformed or repealed because many experts believe it is financially unsound. In February 2011, DHHS Secretary Kathleen Sebelius announced a commitment to making the program financially viable. Under consideration are changes in eligibility criteria – including employment and earnings requirements – so that only active workers can enroll, as well as adjusting premiums to rise with inflation. A March 17, 2011, hearing hosted by the House Committee on Energy and Commerce Subcommittee on health provided a forum for better understanding concerns about program solvency.

### **Considerations for States**

Even though CLASS will offer needed cash assistance for personal care and other services to individuals of all income levels once it is fully operational, the cash benefit is not expected to cover all LTSS needs nor will all Americans enroll in the program. Low-income individuals with severe functional impairments and limited financial resources will continue to rely on Medicaid for LTSS.

While the specifics of program administration and shared responsibility between the states and the federal government are yet to be worked out, states are likely to have a significant role in program administration. For example, by January 1, 2012, the DHHS Secretary is required to establish three types of services that could potentially involve state agencies:

- **Eligibility assessment:** The Secretary is required to establish an eligibility assessment system. States could be called on to conduct eligibility determinations.
- **Protection and advocacy:** The Secretary is required to enter into an agreement with each state’s “protection and advocacy system” to provide advocacy services to CLASS beneficiaries. This is to include informing beneficiaries about how to access the appeals process and providing assistance with annual recertification.
- **Advice and assistance counseling:** The Secretary must enter into an agreement with “public and private entities” to provide advice and assistance counseling to beneficiaries on accessing LTSS in the most integrated setting, possible eligibility for other services, development of a service and support plan, information about programs established under the Assistive Technology Act of 1998, and assistance with decision making concerning medical care (e.g., advance directives, living wills, durable power of attorney).

Within two years after enactment of CLASS (i.e., by March 23, 2012), states are required to determine whether existing community-based providers are serving or

have the capacity to serve as fiscal agents or employers of personal care attendants for CLASS beneficiaries. If necessary, states must create such entities without negatively affecting administration of existing self-directed community-based services. Some states are already budgeting for surveys or analyses to meet this requirement.

States should monitor developments with CLASS implementation and consider the following questions:

- How can the state encourage consumers to participate in CLASS? This new benefit should be included in benefits brochures and websites sponsored by ADRCs and state agencies. Case managers and employers should be trained on CLASS.
- How can CLASS complement a state's Long-Term Care Partnership Program? Forty states now have Partnership programs which could provide valuable "wrap-around" benefits for CLASS beneficiaries. States should begin developing strategies now for jointly marketing the programs to consumers.
- How will the state address the requirement to assess the capacity of fiscal agents and employers in the state to serve the personal care attendants of CLASS beneficiaries? States should begin planning such assessments now.
- What is the availability of direct care workers in the state and will there be sufficient workers to serve CLASS beneficiaries? States are exploring a variety of strategies to expand the direct care workforce, ranging from expanding training programs to developing collaboratives that provide health insurance and other benefits for direct care workers.
- How does the state anticipate providing advocacy services to CLASS beneficiaries? Which agency would have responsibility? Could the services be built on the existing service infrastructure?
- If states are called upon to play a role in CLASS eligibility assessments and/or advice and assistance counseling, how would the state go about this? Could this be integrated into the state's current processes and systems? What are the benefits to the state and to beneficiaries?

### **Promoting Integrated Care for Dual Eligibles**

Integrated care programs for dual eligibles hold much promise, but barriers to coordinating Medicare and Medicaid benefits and payment streams and structuring incentives to minimize cost-shifting across the two programs must be addressed.



The Federal Coordinated Health Care Office (FCHCO) authorized by Section 2602 of the ACA is now in operation. Closely aligned with CMMI, FCHCO is charged with improving the coordination between the federal government and the states to improve access to services for dual eligibles. FCHCO intends to a) provide states with analytical tools to evaluate service utilization and costs for duals; b) identify administrative, regulatory, and legislative policies that would improve the integration of Medicare and Medicaid services; and c) encourage state innovation through technical assistance and demonstrations.

In April 2011, CMMI will announce awards for design contracts to up to 15 states of up to \$1 million each to design innovative service delivery and payment models for dual eligibles. States at a “medium” or “high” level of readiness to launch integrated care programs were encouraged to apply. CMMI will provide technical assistance to awardees. CMMI anticipates additional opportunities for states in the future, so states are advised to monitor the CMMI website at <http://innovations.cms.gov/>.

The ACA authorizes five-year approval or renewal periods for certain Medicaid waivers serving dual eligibles (Section 2601). This includes demonstration programs under section 1115 of the Social Security Act, which are normally approved for an initial five-year period with extensions of three years. Also included are Section 1915(b) waivers, which are on a two-year approval and renewal cycle, and Section 1915(c) waivers, which receive initial approval for three years, followed by five-year renewal periods. Until now, states with concurrent 1915(b)(c) waivers for integrated care programs for dual eligibles were forced to contend with waivers for the same program that were on different renewal cycles. Concurrent five-year approval and renewal periods will greatly simplify waiver administration for states. As concurrent waivers come up for renewal, CMS is working with states to align the waiver periods.

A number of states have or are developing integrated care programs that encourage dual eligibles to enroll with a Medicare Advantage Special Needs Plan (SNP) operated by the same health plan that provides their Medicaid benefits. Section 3205 of ACA extends the authority for SNPs to 2014. The ACA also allows DHHS to apply a frailty payment adjustment for SNPs that serve dual eligibles in fully integrated programs with capitated contracts for Medicaid benefits. This provision provides an additional financial incentive for health plans to offer SNPs for dual eligibles.



## Final Thoughts for States

In addition to the opportunities discussed above, Section 2405 of the ACA authorizes \$10 million in each of FYs 2010-2014 to enable states to continue to develop their network of ADRCs. As with MFP Demonstration funding, states should be sure to take advantage of ADRC funding for infrastructure building, particularly around single-point-of-entry systems which are a requirement for other ACA initiatives such as the State Balancing Incentive Payments program.

To help build the future LTSS workforce, Section 5302 of the ACA authorizes grants to institutions of higher education for tuition assistance for direct care workers. Forward-thinking states will seek ways to collaborate with educational institutions on workforce development and employment opportunities.

States have long been the innovators in LTSS. The ACA offers a number of mechanisms to promote LTSS infrastructure building and systemic change. States should carefully examine all of the options and determine how they might be leveraged to work together to strengthen and expand the state's LTSS system.

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