Deficit Reduction Act of 2005

Redesigning Medicaid Long Term Care

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OVERVIEW

- Public Law 109-171 and Implications for States
  - Signed into Law on February 8, 2006
  - March 31, 2006 Letter to Governors
  - State Medicaid Director (SMD) Letters Issued to Simplify the Process for States
  - Offers States Flexibility for Medicaid Reform

Offers States Flexibility for Medicaid Reform

- Cover More People at a Lower Cost
- Transform Long Term Care from Institutionally Based to Consumer Controlled
- Benefit Flexibility
- Co-payment Flexibility

Medicaid Spending

- In 2003 – Total Medicaid Spending - $232 Billion
- 8.4 Million Individuals with disabilities account for
  - 44% of Medicaid expenditures ($102 Billion in 2003)
- 5.1 Million low-income elderly account for
  - 24% of expenditures ($55.5 Billion in 2003)
- $82.3 Billion is for long term care

DRA and Long-Term Supports

- Allows reform for State Medicaid Programs
- From institutionally-based, provider-driven
- To person-centered and consumer-controlled
- Commitment to independence, choice, and dignity
- Decrease in costs

Increasing Access to Community-Based Care through State Plan Options and Demonstration Programs

Section 5302: Rural Program for All-inclusive Care for the Elderly (PACE) Provider Grant Program

- PACE – capitated benefit for frail elders.
  - Medicare and Medicaid pay PACE center monthly capitation.
  - PACE center provides comprehensive services (at risk).
  - Services must include all Medicaid and Medicare services but can include other services suggested for an individual by an interdisciplinary team.
- Grants awarded for site development to PACE providers that serve a rural area (rural PACE pilot sites.)
- $7.5 million for up to 15 rural PACE pilot sites with no more than $750,000 to one site.
- Establishes some cost outlier protection for first 3 years (for costs in excess of $50K per individual annually.)

Section 6062: Expands Coverage to Families with Disabled Children

- Prior to DRA, children with disabilities could be eligible in a variety of ways, some related to disability status.
- States could not impose cost sharing.
- January 1, 2007 – States have the option to allow families with income up to 300% Federal Poverty Level (FPL) to buy Medicaid coverage for their disabled children.
  - 300% FPL = $60,000 annually or $5,000 monthly for a family of four.
- States may impose monthly premiums based on a sliding scale, but cost sharing is capped (<200% - 5%; 200-300% - 7.5%)

Section 6063: Community-based Alternatives to PRTFs

- Home and Community Based Services (HCBS) alternatives were not previously available to any individuals in psychiatric residential treatment facilities (PRTFs)
- $218 million over 5 years to conduct demonstration projects in up to 10 states.
- To improve States' ability to serve children under age 21 with serious emotional disturbances and their families by expanding the availability of HCBS.

Section 6071: Money Follows the Person Rebalancing Demonstration

- $1.75 billion over 5 years in competitive grants. This is the largest demonstration in Medicaid history.
- To support targeted reforms to transition eligible individuals from institutions to community settings.
- Enhanced Federal Medical Assistance Percentages (FMAP) rate for a period of 1 year for each person transitioned.
- Enhanced FMAP Formula (100+current FMAP/2)

Section 6086: Home and Community Based Services (HCBS) State Plan Option

- States previously had the ability to offer HCBS programs through Section 1915(c) waivers.
  - Cost Neutrality
  - Approved for 3 years, then renewed at 5-year intervals
- Approximately 290 HCBS waiver programs were operating in 49 states and DC when the DRA passed.
- January 1, 2007 - States may offer HCBS as a state plan optional benefit to the elderly and disabled.
- Breaks the "eligibility link" between HCBS and institutional care.
- Instead states will establish an individual "needs-based criteria" for each individual.

Section 6087: State Plan Option for Self-directed Personal Care (Cash and Counseling)

- Self-direction refers to the increased use of discretion by beneficiaries over key elements of health care services.
- Before DRA, some self-direction was possible through the state plan or an HCBS waiver. Other types of self-direction required an 1115.
- Under the new optional self-directed personal care benefit, individuals may:
  - Purchase personal assistance services using an individual budget and service plan.
  - Hire, fire, supervise, and manage individuals providing services (including legally responsible relatives.)
  - Purchase certain items that increase independence or substitute for human assistance (ex: microwaves, accessibility ramps, etc.)
- Not subject to comparability or statewideness requirements.

Eligibility/Post-Eligibility

Section 6021 – State Long-Term Care Partnership Program

- Goal: To help individuals to take more responsibility in planning for and financing their future LTC needs.
- Encourages the purchase of private long term care insurance.
- Assets that were protected during the eligibility determination are also protected in the estate recovery process.
- “Grandfathers” certain existing partnership programs.

State Long Term Care Partnership Program

- Defines a “Qualified State Long Term Care Partnership” as-

  An approved state plan amendment that provides a dollar-for-dollar resource disregard for the purchase and use of LTC insurance.

- Allows purchasers of qualified Long Term Care Insurance to receive Medicaid while protecting assets.

State Long Term Care Partnership Program

The policy must :

- Cover an insured who is a resident of the state;
- Meet the IRS code definition of a qualified long term care insurance policy;
- Meet the National Association of Insurance Commissioner (NAIC) model Act and regulations; &
- Provide inflation protection.

Sections 6011 and 6016: Transfer of Assets Reform

- Previously, the “look-back” period was 36 months (60 months for certain trusts.) The penalty period began when the asset was transferred.
- Look-back period now extended to 60 months.
- Penalty period starts when the transfer is made, or person becomes eligible for Medicaid (whichever is later.)
- States must penalize partial month transfers.
- Specific requirements for granting waivers because of undue hardship.
- Some promissory notes, loans, private mortgages, life estates may be treated as transfers of assets.

Provisions Affecting Long Term Care

Medicaid Eligibility

- Section 6011 – Lengthening look-back period: change in beginning date for period of ineligibility.
- Section 6012 – Disclosure and treatment of annuities.
- Section 6013 – Application of "income-first" rule in applying community spouse's income before assets in providing support of community spouse.
- Section 6014 – Disqualification for long-term care assistance for individuals with substantial home equity.
- Section 6015 – Enforceability of continuing care retirement communities (CCRC) and Life Care Community Admission Contracts.
- Section 6016 – Additional reforms of Medicaid asset transfer rules.
- Section 6036 – Improved enforcement of documentation requirements.

Web Resources

- CMS DRA:
  www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp#TopOfPage
- CMS State Medicaid Director Letters (SMDLs):
  www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage
- Long Term Care Partnership Programs:
  American Association of Retired Persons (AARP):
  www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html
  Insurance Information Institute (III):
  www.iii.org/individuals/longtermcare/ltc_partnership/
- Kaiser Article on Medicaid LTC and DRA: www.kff.org/medicaid/upload/7486.pdf

Thank you!