U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Short Long-Term Care Summary Under the Health Security Act

March 1994

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This discussion paper was prepared by DALTCP as a follow-up document to Health Care Reform activities. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

SHORT LONG-TERM CARE SUMMARY UNDER THE HEALTH SECURITY ACT

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Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

The long-term care component of the Health Security Act has six parts. Taken together, they will have a major impact on the public and private, sectors' efforts to off er comprehensive, high quality, affordable long term care for people with disabilities. **The centerpiece of the plan is a major expansion in home and community-based services for people with severe disabilities**. The other components are:

- Improvements in Medicaid coverage for institutional care.
- Standards to improve private long-term care insurance and tax incentives to encourage people to buy it.
- Tax incentives to help people with disabilities to work.
- Acute/long-term care integration demonstrations.
- A performance review of all the components of the new long-term care program.

EXPANDED HOME AND COMMUNITY BASED SERVICES

The American Health Security Act significantly expands home and community-based services for individuals with severe disabilities without regard to income or age. The expanded home and community-based service program is a federal/state partnership.

The Home and Community-Based Services program complements other federal sources of financing for home and community based services. It does not reimburse for services covered under the nationally guaranteed benefit package or Medicare, both of which provide comprehensive coverage for acute medical services, as well as limited post acute services such as home health, extended care and rehabilitation.

Eligibility: The Secretary of the Department of Health and Human Services (HHS) will issue regulations establishing uniform eligibility criteria and assessment protocols. To be eligible, an individual must be in one of the following categories. The first three categories apply to individuals of all ages; the final category applies only to children under age six. There is no individual entitlement to services under this program.

- Requires hands-on or stand-by personal assistance, supervision or cues in three or more of five activities of daily living (ADLs): eating, dressing, bathing, toileting and transferring in and out of bed.
- Presents evidence of severe cognitive or mental impairment.

- Has severe or profound mental retardation.

- Is under age six and would otherwise require hospital or institutional care for a severe disability or chronic medical condition.

Benefits: In order to receive benefits under the program, an individual must be determined eligible; in addition, the individual must undergo a standardized assessment and have an individualized plan of care developed. At a minimum, a state's array of services must include personal assistance (both agency administered and consumer-directed) for every eligible category of participant.

In addition, states must identify other community-based long-term care services that will be covered under the program. They may include, but are not limited to: case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, habilitation and rehabilitation, supported employment, and home health services. Room and board are not covered. States may offer vouchers or cash directly to consumers or capitate benefits to health plans or other providers.

Services maybe delivered in a person's own home, a range of community residential arrangements, or outside the home, except in licensed nursing homes or intermediate care facilities for the mentally retarded (ICFs/MR).

Co-insurance: All eligible individuals with incomes above 150% of the federal poverty level pay co-insurance to cover a portion of the cost of all services they receive according to a sliding scale. People with incomes between 150% and 200% of the federal poverty standard pay 10% of the cost of care; between 200% and 250%, people pay 20% and if a person's income is over 250% of poverty, the individual is responsible for paying 25% of the cost of services.

State Administration: To implement the program, each state must have an approved plan, which specifies: administering agency or agencies; services to be covered and how, overall, the needs of all types of eligible individuals will be met; how the state will deal with determining eligibility, developing care plans, coordinating services, reimbursing providers and plans, administering voucher/cash payments, licensing/certifying providers; how the state will allocate resources (including whether and how informal services will be taken into account) how the state will monitor, ensure, and improve service quality, including health and safety concerns; describing the composition and role of the state advisory group; how the new program will be integrated with existing long term care programs; and, assuring that the proportion of low income individuals receiving long-term care services in the state under the new program and Medicaid is at least equal to the proportion of low income individuals in the population.

Quality Assurance: Under the new home and community based service program, states are responsible for developing comprehensive quality assurance

programs that monitor health and safety of participants as well as assure that services are of the highest quality possible. States must develop, for federal approval, quality assurance systems that include consumer satisfaction surveys. In addition, the consumer advisory groups are expected to play a strong role in assuring and enhancing quality in the program.

Consumer Involvement in Governance: The Secretary of DHHS will establish a federal advisory group, made up of a majority of consumers and their representatives, as well as providers, federal and state officials, and local community implementing agencies to advise the government and the states on all aspects of the new long-term care program.

In addition, each state will be required to establish a similarly constituted group. This advisory group will consult with the state before the state plan is developed and advise the state on guiding principles and values, policy directions and specific components of the plan. The group will continue to consult with state officials throughout plan development, and during implementation and evaluation of the program. The members of the advisory group will participate in public hearings on the plan and ensure public comments are addressed. The group is also required to submit, as a component of the state plan, detailed comments on all aspect's of the plan, including its level of consumer responsiveness.

Administrative Costs: The costs of administering the program including the eligibility determination process and care planning are included under the national budget. Differential Federal administrative match rates will be established. At full phase in administrative costs are limited to 10% of each state's budget for this program.

National Budget. HHS will establish a national budget for the home and community-based care (HCBC) program, based on the estimated cost of providing HCBC services to persons with severe disabilities. After the program is fully phased-in, the budget increases annually, consistent with the rate of increase for the national health care budget and the growth in the number of persons with severe disabilities.

States will be allocated a maximum budget based primarily on the number of persons with severe disabilities living in their state. The program will be paid for through Federal and state funds, with copayments from recipients. When the program is fully phased in, the Federal share of program costs ranges from 78% to 95%, with states paying 5% to 22% of public costs. The program will be phased in over seven years.

State Allocation Formula. The budget for each state will equal: (# of severely disabled * 80% of average budget per eligible * wage adjustment) + coinsurance subsidy. It is calculated based on a formula that takes into account the number of people with severe disabilities, an average budget per eligible individual, a wage adjustment factor, and an adjustment to take into account consumer cost sharing. The allocation will be updated based on the prevalence rate of severe disability, state

population estimates, the wage index, a coinsurance index, and average spending per eligible individual.

MEDICAID COMMUNITY LONG TERM CARE CONTINUES

In addition to the enactment of the major new community-based long-term care program, current Medicaid community long-term care programs will continue essentially unchanged. Specifically, all current rules and state and federal requirements are retained for: personal care; home and community-based waivers; the frail elderly program; Community Supported Living Arrangements; targeted case management; and the long-term care portions of Medicaid home health, clinic services and rehabilitation services. As is now the case, Medicaid community long-term care services are a state option, with one exception: states must assure that no individual receiving Medicaid community-based long-term care services immediately prior to the enactment of the Health Security Act is harmed because the state participates in the new program.

Medicaid Home and Community-Based service components may be used to serve low-income people with lesser levels of disability. States may elect to serve persons with severe disabilities under Medicaid, the new program, or both.

MEDICAID ELIGIBILITY IMPROVEMENTS FOR INSTITUTIONAL CARE

The American Health Security Act amends Title XIX of the Social Security Act to improve coverage for institutional care under Medicaid by: (a) requiring states to establish a medically needy program or all residents of a nursing home or ICF/MR; raising the living allowance of nursing homes and ICF/MR residents from $30 to $50 per month; and offering states the option of allowing nursing home and ICF/MR residents to retain up to $12,000 in personal assets in determining eligibility for Medicaid coverages up from the current limit of $2,000.

PRIVATE LONG TERM CARE INSURANCE: REGULATION AND TAX INCENTIVES

The plan includes significant provisions to improve the private long term care insurance market, with definitions, minimum federal standards, and tax incentives to encourage people to buy these products. There will be a federal grant program for

consumer information, counseling and technical assistance to educate consumers about long-term care insurance.

A five member Long-Term Care Insurance Advisory Council will be appointed by the Secretary of HHS to advise and assist the Secretary on matters relating to long-term care insurance and to monitor the development of the insurance market.

The Secretary of the Department of HHS, after input from the Council, will promulgate federal regulations for long-term care insurance offerings within two years of enactment of the Health Security Act. These regulations will include requirements for: nonforfeiture of benefits in the event of policy lapse; inflation protection; certain preexisting conditions provisions; third party notification of pending lapse under some circumstances; and, definitions of services and eligibility.

Federal regulations will be applied to long term care insurance business practices, including: a requirement for a state appeals process; complaint resolution procedures; training and certification of agents, with limits on their commissions; requirements for premium approval and pricing assumptions; and prohibitions against improper sales practices.

In addition, the Internal Revenue Code will be amended to treat long term care insurance purchases more like health insurance purchases for tax purposes. For instance, payments for long term care policies will be excluded from taxable income, the cost of long term care policies may be included as itemized medical expenses, and employer-paid premiums for long-term care insurance will be treated as deductions for employers and excluded from taxable income for employees.

A NEW TAX CREDIT FOR INDIVIDUALS WITH DISABILITIES WHO WORK

Certain employed individuals who need ADL assistance and who use their own money to buy personal care and personal assistance services may obtain a tax credit for 50 percent of their costs, up to a maximum of $15,000 per year.

ACUTE/LONG-TERM CARE INTEGRATION DEMONSTRATIONS

The Secretary of the Department of Health and Human Services will conduct a demonstration program for integrated models of acute and long-term care services for individuals with disabilities and chronic illnesses. The demonstrations will define integration models, assess their viability, evaluate impact, and determine the

appropriateness of such models in the managed competition structure. The Secretary of HHS will set minimum benefit specifications and ensure that model sites include comprehensive medical benefits, specialized transitional benefits, long term care benefits, or specialized habilitation services for participants with developmental disabilities.

Demonstration sponsors provide enrollment services, client-assessment and care planning, simplified access to services, ongoing integrated acute and chronic care management, continuity of care across settings and services, quality assurance, grievance and appeal procedures, member services and strong consumer participation.

A PERFORMANCE REVIEW OF THE REFORMED SYSTEM

The overall performance of the reform package will be assessed in terms of quality, access, and availability of long-term supports for individuals with disabilities. The Secretary of HHS will submit to the Congress interim and final assessments of the effectiveness of the new package of long-term care reforms specific topics to be covered include: access to community and institutional care, how well the new private insurance standards and incentives are working, whether the new system is containing costs, and how well services are coordinated for individuals.

A more complete version of the long-term care provisions (*Summary of Long-Term Care Provisions Under the Health Security Act*) is available at http://aspe.hhs.gov/daltcp/reports/ltcpsum.htm.