CLASS Act

Summary

The PPACA established the voluntary Community Living Assistance Services and Supports (CLASS) program. It will provide a cash benefit for eligible enrollees, which can be used to purchase community living assistance services and supports.

Beginning in January, individuals 18 and older who are actively employed will be auto-enrolled. Employers as well as individuals may opt-out. Enrollee premiums will be paid through a payroll deduction. While HHS has not yet established premiums (see below), low-income workers and employed full-time students may enroll at the minimum of $5/month. There is a five-year vesting period and individuals must have a certified functional limitation in their activities of daily living for benefits to commence.

Benefits will be placed in an individualized Life Independence Account and beneficiaries will receive a debit card to access funds. The minimum daily benefit will be $50/day and is expected to average $75/day with no lifetime limit, indexed to inflation. Consumer control is a central component of the proposal and has the potential to redefine the long-term care market.

Medicaid will be coordinated with CLASS. Medicaid-eligible CLASS beneficiaries receiving institutional care are able to retain 5% and those receiving home and community-based services may retain 50% applicable cash benefit, with the remainder of the benefit applied toward the cost to the state.

Issues

CBO assumes a 3.5% participation rate in the program and CMS assumes only 2%. Participation rates may be low due to the voluntary nature of the program, the lack of federal subsidy, adverse selection, and the minimum premium of $5.00.

The average daily benefit in the private LTC insurance market is $150.00 and does not vary by functional limitation, but does vary by setting of care. Individuals who purchase private LTC insurance have a benefit duration between three and five years, the CLASS program does not limit the duration of the benefit. The estimated average monthly premium for a $50.00 per day private insurance policy covering three years of services is about $70.00, and for a five-year policy is about $94.00 per month. Without a durational limit, CBO and CMS have estimated premiums to be much higher. CBO estimates that the average monthly premium in 2011 will be $123.00 and CMS estimates that the average monthly premium in 2011 with $240.00, this estimate largely reflects their assumptions about increased adverse selection by the participants.

Lastly, many articles have cited the ability of the Secretary of HHS to push back timelines and it is probable that payroll deductions will commence sometime later that the January 2011 timeline in the PPACA.
State Balancing Incentive Payment Program

Summary

PPACA established the State Balancing Incentive Payment Program. This is a first ever financial incentive for states to accelerate efforts to support home and community-based services (HCBS) and reduce institutionalization in the Medicaid program.

The program has a fixed term: October 1, 2011 – September 30, 2015. States spending less than 25% of on HCBS may apply for incentive payments of 5% additional federal match through the program’s term if they agree to exceed 25% spending by the program’s end date. Similarly, states between 25 and 50% spending for HCBS would qualify for a 2% incentive for meeting or exceeding the 50% threshold.

States must make the following structural changes within 6 months of application:

- “Single entry point” for information, referrals and applications for all long-term care services and supports statewide.
- “Conflict-free case management” across all affected HCBS programs that would likely separate service provision from service coordination.
- “Standardized assessment” statewide and across programs for determining needs and developing service plans.

Issues

The current CMS position is that services for the developmentally disabled will be grouped with those for aging and physical disabilities. If this interpretation is taken, it is likely that few states will apply and no states will qualify for the 5% match. In 2008, the benchmark year, the commonwealth’s HCBS programs for the aging and persons with physical disabilities accounted for 18% of total long-term care spending versus 82% for nursing facilities. Pennsylvania will likely reach 24% spending this fiscal year and is ideally positioned to benefit from this incentive if targeted populations are allowed. The Office of Long-Term Living estimates a four year savings of over $200m from the additional FMAP. With services for the developmentally disable included, Pennsylvania would qualify for the 2% incentive but require a much greater investment to reach the 50% threshold.

Secondly, a maintenance of effort (MOE) requirement in the law prohibits changes to eligibility and service plan development by states. Since the program’s timing has overlap with the American Recovery and Reinvestment Act (ARRA), states applying for the incentive would have to accept an extension of the 2008 ARRA MOE. This will likely dissuade applicant states who simultaneously implement cost containment in HCBS programs.

Lastly, guidance is not expected until next summer, which unless expedited, will be a major setback for states with appropriation cycles ending prior to final instructions.
Community First Choice Option

Summary
Prior to PPACA and today, 35 states provide assistance with personal care in the Medicaid program through the state plan. While Pennsylvania does not offer this coverage as a state plan service, qualified individuals may receive personal care through home and community-based waiver programs that serve as alternatives to nursing facilities and intermediate care facilities for the mentally retarded.

Beginning on October 1, 2011, the Community First Choice Option will offer a 6% enhancement to a states federal match for personal care and related services for state that:

- Offer personal care to eligible individuals 21 and older up to 150% of FPL or the same level as a states home and community-based waiver programs (300% for Pennsylvania).
- Establish an Implementation Council with a majority consumer membership.
- Monitor quality through health outcomes and incorporate consumer feedback.

The program does not have an expiration date and the enhancement could potentially exist indefinitely. The Secretary of Health and Human Services will submit an interim report to Congress in 2013 and a final evaluation in 2015.

The waivers operated by the Office of Long-Term Living will spend nearly $800 million in total funds this fiscal year. Personal care and related services account for over 80% of waiver costs in each program and is often much higher. It is estimated that the additional 6% FMAP would save over $200 million in 5 years.

Issues
States like Pennsylvania that do not offer personal care in their Medicaid state plan would make this service an entitlement for qualified individuals. States that offer personal care through waiver programs may create waiting lists based on limited availability in funds.

Additionally, consideration should be given to the scope of the program. States may restrict the services definition to specific populations, such as those meeting nursing facility clinical eligibility. However, the commonwealth may want to consider a less restrictive definition that could enable services under state funded programs to receive federal match. For example, many nursing facility clinically ineligible consumers may meet the income guidelines but receive state funded services through Area Agencies on Aging or through the Act 150 program. Matching these services may outweigh potential for caseload increases.