

Medicaid Coverage of Long-Term Services and Supports

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Summary

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time. Medicaid plays a key role in covering LTSS to aged and disabled individuals. As the largest single payer of LTSS in the United States, federal and state Medicaid spending accounted for \$133.5 billion or 42.1% of all LTSS expenditures in 2011 (\$317.1 billion). LTSS are also a substantial portion of spending within the Medicaid program relative to the population served, accounting for over one-third (35.6%) of all Medicaid spending. Of the 66 million total enrolled Medicaid population, an estimated 4.2 million (or 6.4%) Medicaid beneficiaries received LTSS in 2010.

Medicaid funds LTSS for eligible beneficiaries in both institutional and home and community-based settings, though the portfolio of services offered differs substantially by state. Moreover, states are required to offer certain Medicaid institutional services to eligible beneficiaries, while the majority of Medicaid home and community-based services (HCBS) are optional for states. In recent decades, federal authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include HCBS. As a result, the share of Medicaid LTSS spending for HCBS has more than doubled, accounting for 20.8% of Medicaid LTSS spending in 1995 to just over half (50.6%) of total Medicaid LTSS spending in 2011.

States now have a broad range of coverage options to select from when designing their LTSS programs. In general, Medicaid law provides states with two broad authorities, which either cover certain LTSS as a benefit under the Medicaid state plan or cover home and community-based LTSS through a waiver program which permits states to ignore certain Medicaid requirements in the provision of these services. Given the range of available coverage options, states continue to enhance or expand their LTSS delivery systems to cover additional services or target services to specific populations with a focus on HCBS. In FY2012 and FY2013, states reported expanding their state plan benefits to include HCBS through the Section 1915(i) HCBS state plan option, the Section 1915(k) Community First Choice (CFC) option, and Programs for All-Inclusive Care of the Elderly (PACE). States also reported adopting new HCBS waiver programs or expanding existing waivers to include additional services. Finally, states reported efforts to implement demonstrations and other grant activities to enhance or expand their LTSS delivery systems under the Money Follows the Person (MFP) Rebalancing Demonstration and the Balancing Incentive Payments (BIP) Program, as well as efforts to implement or expand the financing and delivery of Medicaid LTSS through managed care arrangements.

This report provides a description of the various statutory authorities that either require or otherwise allow states to cover LTSS under Medicaid. The **Appendix** provides a brief legislative history of Medicaid LTSS from Medicaid's enactment and initial coverage requirements for institutional care through the evolution of HCBS options available to states. A discussion of changes to Medicaid made by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) with respect to LTSS coverage options is also provided.

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Introduction

Medicaid plays a key role in covering long-term services and supports (LTSS) to aged and disabled individuals. As the largest single payer of LTSS in the United States, Medicaid LTSS spending in 2011 (combined federal and state) totaled \$133.5 billion and accounted for 42.1% of all LTSS expenditures (\$317.1 billion).¹ LTSS are also a substantial portion of spending within the Medicaid program relative to those served. In 2011, Medicaid LTSS accounted for over one-third (35.6%) of all Medicaid spending despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population. An estimated 4.2 million Medicaid beneficiaries (or 6.4%) of the 66 million total enrolled Medicaid population received LTSS in FY2010.² In other words, 6.4% of those enrolled in Medicaid accounted for over one-third of total program costs.

Medicaid funds LTSS for eligible beneficiaries in both institutional settings and home and community-based settings, though the portfolio of services offered differs substantially by state. Federal law requires that state Medicaid programs cover certain LTSS for eligible beneficiaries, such as nursing facility care. However, states have a range of options that allow LTSS coverage of home and community-based services (HCBS) for Medicaid beneficiaries based on need, and that allows states to target such coverage to particular groups of individuals (i.e., older adults and individuals with physical disabilities, or individuals with a specific disease or condition such as HIV/AIDS). These flexibilities under Medicaid law have led to widespread variation in state Medicaid LTSS benefit packages offered to elderly and disabled individuals.

What Are Long-Term Services and Supports?

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time.

One important issue for Medicaid LTSS coverage is its perceived “institutional bias.” The original 1965 Medicaid law established that eligible Medicaid beneficiaries are entitled to nursing facility care. In more recent decades, federal Medicaid statutory authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include optional HCBS. For example, the addition of the Section 1915(c) HCBS waiver to Medicaid law in 1981³ and subsequent statutory amendments that created new Medicaid state plan benefit options have allowed states to further the provision of HCBS. Subsequent legislative and administrative activities to expand Medicaid HCBS, in part, were prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,⁴ which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) further adds to the

¹ Based on CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 16, 2012. For further information on LTSS financing, see CRS Report R42345, *Long-Term Services and Supports: Overview and Financing*, by Kirsten J. Colello, Janemarie Mulvey, and Scott R. Talaga.

² Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, June 14, 2013, pg. 102.

³ Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

⁴ 527 U.S. 581 (1999). For further information on *Olmstead v. L.C.*, see CRS Report R40106, *Olmstead v. L.C.: Judicial and Legislative Developments in the Law of Deinstitutionalization*.

range of options available to states that want to pursue HCBS coverage expansion. As a result, states have a broad range of coverage options to select from when designing their LTSS programs. Moreover, the share of Medicaid LTSS spending for HCBS has doubled over time, from about 20.8% of Medicaid LTSS spending in 1995 to just over half (50.6%) of total Medicaid LTSS spending in 2011.

In FYs 2012 and 2013, states continued to report efforts to enhance their HCBS offerings within their Medicaid LTSS delivery systems (29 states in FY2012 and 34 states in FY2013).⁵ In FY2013, no state reported plans to enhance institutional services, while only two states reported doing so in FY2012. States reported adopting new HCBS waivers or expanding existing waivers to include additional services. Other examples of state expansion activities included offering HCBS through the Section 1915(i) HCBS state plan option and the Section 1915(k) Community First Choice (CFC) option, and expanding the Program for All-Inclusive Care of the Elderly (PACE). States also reported efforts to implement grants and demonstrations under the Money Follows the Person (MFP) Rebalancing Demonstration and the Balancing Incentive Payments (BIP) Program, as well as efforts to implement or expand Medicaid managed LTSS programs, among other policy options.

This report provides a description of the various statutory authorities and other legislative provisions that either require or otherwise allow states to cover LTSS under Medicaid. The report's **Appendix** provides a brief legislative history of Medicaid LTSS from Medicaid's enactment and initial coverage requirements for institutional care through the evolution of HCBS options available to states. A discussion of ACA's changes to Medicaid law with respect to Medicaid LTSS coverage options is also provided.

Medicaid LTSS Coverage

Medicaid is a means-tested individual entitlement program which finances the delivery of health care and LTSS to certain low-income individuals. Established under Title XIX of the Social Security Act (SSA), the Medicaid program is state-operated, within broad federal guidelines, and is funded by both state and federal revenues.⁶ The federal share for Medicaid service costs is determined by the federal medical assistance percentage (FMAP). FMAP rates are based on a formula that provides higher federal reimbursement to states with lower per capita income relative to the national average (and vice versa).⁷ Historically, to qualify for Medicaid individuals must meet certain categorical and financial requirements. To qualify for Medicaid LTSS, individuals must also meet state-defined level-of-care criteria.⁸

⁵ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Today; Preparing for Tomorrow, A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, October 2012, at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8380.pdf>.

⁶ For more information on Medicaid see, CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

⁷ FMAP rates have a statutory minimum of 50% and a maximum of 83%, although some Medicaid services receive a higher federal match rate. For FY2013, the FMAP rate ranges from 50% to 74%, with the federal contribution covering about 57% of the total cost of Medicaid in a typical year. The FMAP rate for Medicaid administrative costs are typically capped at 50%. For further information, see CRS Report RL32950, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2013*, by Alison Mitchell and Evelyn P. Baumrucker.

⁸ To define level-of-care criteria, states may use "functional" criteria such as an individual's ability to perform certain Activities of Daily Living (ADLs, e.g., eating, bathing, dressing, and walking) or to perform certain Instrumental Activities of Daily Living (IADLs, e.g., shopping, housework, and meal preparation) that allow an individual to live (continued...)

State Medicaid LTSS delivery systems include the provision of services in two types of settings: (1) services provided in institutional settings, such as a nursing facility, and (2) services and supports provided in home and community-based settings, such as a private home, adult day facility, or assisted living facility.⁹ States are required to offer certain Medicaid institutional services. However, the majority of home and community-based services (HCBS) offerings are optional for states.

Medicaid law and other provisions in SSA contain several authorities that permit states to offer LTSS to individuals in need of such services. In general, Medicaid law provides states with two broad authorities, which either cover certain LTSS as a benefit under the Medicaid state plan or cover home and community-based LTSS through a waiver program which permits states to waive certain Medicaid requirements to allow the provision of these services. The following describes the Medicaid state plan authority and various waiver authorities that either require or permit states to cover LTSS. In addition, other Medicaid statutory provisions that offer states incentives to further enhance or expand their LTSS delivery systems are identified.

LTSS State Plan Coverage

The state plan is the contract between a state and the federal government which describes how that state administers its Medicaid program and provides assurance that the state will meet federal Medicaid requirements in order to receive matching federal funds for program activities. In general, the Medicaid state plan describes those groups of individuals to be covered, benefits to be provided, methodologies for providers to be reimbursed, and administrative requirements that states must meet to participate.¹⁰ State plans are developed by the states and approved by the Centers for Medicare & Medicaid Services (CMS). States may update their state plans by submitting a state plan amendment (SPA) for CMS review and approval. Once a state plan or SPA is approved, states may receive matching federal funds for covered benefits without further need for CMS review or approval.

Medicaid statutory provisions require states to cover certain benefits under the “traditional” Medicaid state plan program (i.e., mandatory benefits) and give states the option to cover others (i.e., optional benefits). With respect to state plan benefits, federal law requires states to meet the following guidelines with some exceptions:

(...continued)

independently in the community. Other states may use “clinical” level-of-care criteria that include diagnosis of an illness, injury, disability or other medical condition, treatment and medications, and cognitive status, among other information. Most states use a combination of functional and clinical criteria in defining the need for LTSS. For further information on state specific level-of-care criteria, see L. Hendrickson and G. Kyzr-Sheeley, “Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment,” Rutgers Center for State Health Policy, March 2008.

⁹ CMS has issued two proposed rules to solicit public comment regarding a proposed definition of HCBS setting: (1) Department of Health and Human Services, “Medicaid Program; Home and Community-Based Services (HCBS) Waivers,” 76 *Federal Register* 21311-21317, April 15, 2011; and (2) Department of Health and Human Services, “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provide Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule,” 76 *Federal Register* 26362-26406, May 3, 2012.

¹⁰ CMS, *Medicaid State Plan Amendments*, at <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html>.

- Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity or functional level-of-care criteria.
- Within a state, services available to certain groups of enrollees must be equal in amount, duration, and scope. These requirements are referred to as the “comparability” requirement.
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, also known as the “statewide” requirement.
- With certain exceptions, beneficiaries must have “freedom of choice” among health care providers or managed care entities participating in Medicaid.

Waiver programs, on the other hand, allow states to provide benefits outside of some of these rules and to test new or existing ways to finance and deliver services. For example, waiver programs allow states to extend benefits that are, among other things, neither comparable across groups nor statewide. States must submit a separate waiver application for CMS review and subsequent approval. Unlike Medicaid state plan benefit coverage, Medicaid waiver benefit coverage is time limited for the duration of the waiver (e.g., three or five years) and must be renewed by the state subject to CMS approval. Together, these state plan and waiver authorities constitute a range of options that states have in designing their LTSS benefit packages for eligible beneficiaries.

Figure 1 lists selected LTSS state plan benefits by the setting in which they are provided (institutional vs. HCBS) and whether they are a mandatory or optional state plan benefit.

Figure 1. Selected Mandatory and Optional Medicaid State Plan Long-Term Services and Supports (LTSS)

	MANDATORY BENEFITS	OPTIONAL BENEFITS
Institutional Services	Nursing Facility Services [age 21 and older]	Nursing Facility Services [under age 21]
		Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)
		Services in Institutions for Mental Diseases (IMD) [age 65 and over]
		Inpatient Psychiatric Care [under age 21]
Home & Community-Based Services	Home Health Services	Case Management/Targeted Case Management
	Transportation to/from medical services	Personal Care Services
		Rehabilitation
		State Plan Home and Community-Based Services [Sec. 1915(l) of the SSA]
		Community First Choice [Sec. 1915(k) of the SSA]

Source: CRS; for the full-range of Medicaid benefits see, the Centers for Medicare & Medicaid Services web-site at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

Note: The preferred term is individuals with “intellectual disability (ID),” instead of “mental retardation.” Federal law and regulations use the term “intermediate care facilities for the mentally retarded” and abbreviation “ICF/MR,” which is the term and abbreviation used here. “Transportation to/from medical services” includes the provision of acute health care services, thus it is not specifically LTSS.

Mandatory State Plan Benefits

Among the Medicaid state plan LTSS benefits described below, the only state plan benefits that participating states are required by federal law to cover are nursing facility services, home health, and non-emergency transportation to and from medical providers. The following describes those LTSS benefits that states are required to cover under their Medicaid programs—nursing facility services, home health services, and non-emergency medical transportation. States must offer these services to eligible beneficiaries statewide. However, each state determines the amount, duration, and scope of these services.

Nursing Facility Services

States are required to cover nursing facility services for beneficiaries ages 21 and over under their Medicaid plans. States have the option to cover nursing facility services for beneficiaries under age 21. Beneficiaries must also meet state-defined nursing home eligibility criteria, referred to as level-of-care criteria. Nursing facility services include nursing care and related services, dietary services, physician services, specialized rehabilitation services (e.g., physical and occupational therapy, speech pathology and audiology services, and mental health rehabilitative services), emergency dental care, and pharmacy services.¹¹ Medicaid coverage of nursing facility services also includes room and board.

Home Health Services

Home health services are a mandatory benefit linked to requirements that states provide nursing facility care for certain individuals.¹² States must cover home health services for categorically eligible individuals ages 21 and older who are *entitled* to nursing facility coverage under a state's Medicaid state plan.^{13,14} If a state also chooses to cover nursing facility services for individuals *under* age 21, home health services are a required benefit for these Medicaid beneficiaries as well. Medicaid eligibility for the home health services benefit is not conditional on a need for institutional care or the need for skilled nursing or therapy services.

¹¹ 42 C.F.R. § 483, subpart B.

¹² For more information, see U.S. Department of Health and Human Services, *Understanding Home and Community-Based Services: A Primer*, 2010, <http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm>.

¹³ In general, there are two broad classifications of Medicaid eligibility groups: (1) categorically needy (which include both mandatory and optional eligibility groups) and (2) medically needy (optional eligibility group). Historically, Medicaid eligibility was subject to categorical restrictions that generally limited coverage to certain categories of individuals (i.e., “categorically needy”) such as the elderly, persons with disabilities, or members of families with dependent children. States may choose to cover the “medically needy” who are individuals whose income is too high to qualify as categorically needy. Medically needy coverage is particularly important for the elderly and persons with disabilities, since this pathway allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid.

¹⁴ Individuals who are entitled to nursing facility services are not necessarily eligible for such care. To be eligible for nursing facility services, entitled individuals must also meet state-based nursing facility eligibility criteria or level-of-care criteria. Federal regulations specify coverage groups entitled to home health as (a) categorically eligible individuals ages 21 or over; (b) categorically eligible individuals under age 21 if the state plan provides nursing facility services to this population group; and (c) medically needy individuals to whom nursing facility services are provided under the state plan (42 CFR § 441.15).

At a minimum the home health service benefit includes nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for in home use.¹⁵ States have the flexibility to offer additional therapeutic services under the home health benefit, such as physical therapy, occupational therapy, speech pathology, and audiology services. Once the home health benefit is determined, states must offer both the required and optional home health services to all Medicaid beneficiaries entitled to nursing facility services under their state plans. Home health services must be ordered by a physician as part of a written plan of care and reviewed by the physician every 60 days. States must provide home health services to beneficiaries in their place of residence with certain exceptions.¹⁶

Non-Emergency Medical Transportation and Other Transportation Services

States must provide a minimum transportation benefit that ensures necessary transport for Medicaid beneficiaries to and from providers, such as to and from medical visits. States may also provide a transportation benefit beyond these minimum requirements to enable Medicaid recipients of HCBS to gain access to waiver and other non-medical community services, activities, and resources specified by the plan of care. States have the option to provide such transportation as a state plan service or as an administrative expense, with either option eligible for federal Medicaid matching funds (i.e., regular FMAP rate for state plan services and 50% FMAP rate for administrative expenses).

Optional State Plan Benefits

States may cover other types of LTSS under a Medicaid state plan. These optional LTSS benefits assist older individuals and persons with disabilities who live in the community and may need assistance with activities of daily living. Medicaid coverage of these home and community-based services includes coverage of specific benefits such as case management or personal care. States also have authority to cover packages of HCBS benefits targeted at particular groups of beneficiaries. The following describes these coverage options in greater detail.

Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)

States may provide services to eligible Medicaid beneficiaries residing in Intermediate Care Facilities for individuals with Mental Retardation (ICFs/MR) as an optional service under a state's Medicaid plan. The primary purpose of the ICF/MR is to furnish health and rehabilitative services to persons with intellectual disabilities or other related conditions.¹⁷ ICF/MRs must provide certain services including nursing, physician, dental, pharmacy, and laboratory services.¹⁸ According to CMS, beneficiaries who receive services in an ICF/MR are likely to have other disabilities or conditions in addition to intellectual disabilities, such as seizure disorders, behavior

¹⁵ See 42 C.F.R. § 440.70.

¹⁶ In 1997, Federal Court of Appeals for Second Circuit ruled that home health could be provided outside the home, as long as services do not exceed the hours of nursing care that would have been provided in the home. *Skubel v. Fuoroli*, 113 F. 3rd 330 (2d Cir. 1997).

¹⁷ The accepted term is individuals with “intellectual disability (ID)” instead of “mental retardation.” However, federal Medicaid law and regulations use the term and abbreviation “Intermediate Care Facilities for the Mentally Retarded (ICF/MR),” which is the term and abbreviation used in this report.

¹⁸ 42 C.F.R. § 483.400, subpart I.

issues, and mental illness.¹⁹ Medicaid specifies that the ICF/MR must provide a program of “active treatment,” as defined by the Secretary of Health and Human Services (HHS). Federal regulations refer to “active treatment” as aggressive, consistent implementation of a program of generic and specialized training, treatment, and health services.²⁰ Even though the benefit is optional, in 2010 all 50 states and the District of Columbia (DC) offered services in an ICF/MR.²¹

Services in Institutions for Mental Diseases (IMDs)

States may provide inpatient hospital and nursing facility services for eligible beneficiaries aged 65 and over with mental diseases that reside in Institutions for Mental Diseases (IMDs) under a state’s Medicaid plan, also referred to as “IMD over 65.” IMD services include diagnosis and medical treatment, as well as nursing care and related services under the direction of a physician. In 2010, 47 states and DC offered services in IMDs to individuals age 65 and over.²²

What Is the Medicaid Institution for Mental Diseases Exclusion Rule?

Generally, states are responsible for the costs associated with services provided in an “Institution for Mental Disease” (IMD). The IMD exclusion rule prevents federal Medicaid funds from being used to care for individuals between 21 and 64 years of age who live in an IMD, which is defined as a “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” [42 U.S.C. 1396d(i)]

Two populations may receive Medicaid coverage for services received in an IMD. Thus, federal Medicaid matching payments are available for certain eligible beneficiaries in these settings. These populations are (1) adults age 65 and over; and (2) children under the age of 21 (in general). In the case of children, inpatient psychiatric care is a Medicaid state plan coverage option (described below), which is mandatory when a child’s condition is diagnosed through an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit screen.

The IMD exclusion applies to health providers that are IMDs with 17 beds or more that provide institutionalized services. Thus, health providers may receive federal Medicaid matching funds for partial hospitalization services and day treatment programs which do not require institutionalization. By definition, the IMD exclusion does not apply to settings with 16 or fewer beds, and federal Medicaid matching funds would be available to these providers. According to researchers, “the history of this exemption indicates that Congress was particularly concerned that Medicaid be used to promote small, community based group living arrangements as an alternative to large institutions.”

Source: S. Rosenbaum, J. Teitelbaum, and D.R. Mauery, *An Analysis of the Medicaid IMD Exclusion*, George Washington University School of Public Health and Health Services, 2002.

Inpatient Psychiatric Care

States may provide inpatient psychiatric care to eligible beneficiaries under age 21, often referred to as “Psych Under 21.” Such services are typically provided through psychiatric residential treatment facilities (PRTFs), which provide comprehensive mental health treatment to children and young adults who, due to mental illness, substance abuse, or severe emotional disturbance, are in need of short term mental health treatment. The goal of PRTF programs is to successfully

¹⁹ CMS, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/ICFMR_Background.pdf

²⁰ 42 C.F.R. § 483.440.

²¹ CMS, derived from <http://www.healthcare.gov> and individual state Medicaid websites as of December 2010 and January 2011, personal communication, winter of 2011.

²² Ibid.

return youth to the community. In 2010, 42 states and DC offered the inpatient psychiatric care benefit to eligible beneficiaries under age 21.²³

Case Management and Targeted Case Management Services

States may offer case management services to assist individuals who reside in community settings, or who are transitioning from an institutional to a community setting, in gaining access to needed medical, social, educational, and other services. Case management includes a comprehensive assessment and periodic reassessment of a beneficiary's needs, and development and implementation of a tailored care plan. Examples of case management services include service/support planning, monitoring of services, and assistance to beneficiaries with obtaining other non-Medicaid benefits, such as the Supplemental Nutrition Assistance Program (SNAP), energy assistance, and emergency housing.

States choosing to offer the case management benefit must make it available on a statewide basis. States also have the option to offer a targeted case management benefit to a specified beneficiary population within a specific geographic area. Like the case management benefit, states can use targeted case management to assist such individuals in gaining access to needed medical, social, educational, and other services. To be eligible for either benefit option, Medicaid beneficiaries must meet the state-defined eligibility criteria for that benefit.

Personal Care Services

States may offer personal care services as an optional Medicaid state plan benefit. These services enable older individuals and persons with disabilities or chronic conditions to accomplish certain activities they would otherwise not be able to accomplish independently.²⁴ Personal care services include assistance with performing activities of daily living (ADLs) such as eating, bathing, dressing, toileting, and transferring (from a bed to a chair, etc.). Services may also include assistance with instrumental activities of daily living (IADLs), which facilitate independent living in the community, such as providing light housework, laundry, meal preparation, transportation, and grocery shopping. Assistance may be in the form of hands-on assistance (i.e., actually performing a task for an individual) or cuing so that the individual performs the task by himself or herself. For individuals with cognitive impairments, such assistance may also include cuing and supervision of the task.

States choosing to offer the personal care services benefit must make it available on a statewide basis. Personal care services must be authorized by a physician or, at state option, otherwise authorized under a state-approved plan of care. Services are furnished to individuals at home or, at state option, in other settings (such as a workplace or senior center). Services may not be provided to individuals who are inpatients or residents of hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MRs), or psychiatric institutions. Personal care services must be provided by a qualified provider and may be furnished by family members, with the exception of legally liable relatives (i.e., spouses or parents of minor children). Furthermore, the provision of personal care services may be directed by the beneficiary, including

²³ Ibid.

²⁴ As per Section 1905(a)(24) of the SSA; 42 CFR 440.167; and Section 4480 of the State Medicaid Manual at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

the beneficiary having the ability to hire, train, and supervise personal care attendants.²⁵ In 2009, 31 states and DC covered personal care services under the Medicaid state plan.²⁶

Rehabilitation Services

States can offer a distinct rehabilitation service benefit as a state plan option that provides individuals with services related to the rehabilitation of physical or mental health conditions. The rehabilitative services option is broadly defined as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.” States choosing to offer this benefit must offer it on a statewide basis.

The rehabilitation services option can be provided in community settings, including in an individual’s home or work environment, and can be provided by professionals and paraprofessionals. There is no requirement that rehabilitation services be provided under a physician’s direction. This benefit option is distinct from rehabilitative services offered in institutional settings such as a Medicaid nursing facility or ICF/MRs. Services provided under the optional Medicaid rehabilitation benefit span a wide range of treatments from physical rehabilitation to behavioral health and substance abuse treatment. Often the rehabilitation services assist beneficiaries who have mental health conditions.²⁷ States may also utilize the rehabilitation services option to provide beneficiaries with physical, occupational, and speech therapy, as well as other comprehensive services to treat and help individuals recover from substance abuse disorders. In 2010, 34 states covered rehabilitation services as an optional benefit under the Medicaid state plan.²⁸

Table 1 shows Medicaid LTSS expenditures for certain mandatory and optional state plan services for FY2011, which is the most recent year in which these data are available.

²⁵ Section 1915(j) of the SSA expands participant direction for personal care services for states offering such care under their Medicaid state plan or offering a 1915(c) HCBS waiver program. The 1915(j) authority allows states to disburse cash prospectively to participants who direct their personal assistance services. It also allows participants who direct their state plan personal care services to hire legally liable relatives to provide care (such as spouses or parents) and purchase non-traditional goods and services other than personal care.

²⁶ Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2009 Data Update*, December 2012. Personal care services are also referred to as personal attendant services, personal assistance services, or attendant care services.

²⁷ Crowley, J.S., and M. O’Malley, *Policy Brief: Medicaid’s Rehabilitation Services Option: Overview and Current Policy Issues*, Kaiser Commission on Medicaid and the Uninsured, August 2007.

²⁸ CMS, derived from <http://www.healthcare.gov> and individual state Medicaid websites as of December 2010 and January 2011, personal communication, winter of 2011.

Table 1. Medicaid LTSS Expenditures for Selected Mandatory and Optional State Plan Services, FY2011

Service Type	Total Medicaid Payments (\$ Billions)
Mandatory State Plan Services	
Nursing Facility Services	\$52.4
Home Health Services	\$5.5
Optional State Plan Services	
Intermediate Care Facilities for Individuals with Mental Retardation	\$13.3
Institutions for Mental Diseases (IMDs) ^a	\$3.5
Personal Care Services	\$14.1
Rehabilitative Services ^b	\$2.8

Source: Eiken, S., K. Sredl, L. Gold, et al., Medicaid Expenditures for Long-Term Services and Supports in 2011, Truven Health Analytics, June 2013, based on data identified in CMS- 64 reports and represent total (federal and state) Medicaid payments.

Notes: For FY2011, Medicaid payment data do not include managed care programs in the following states: CA, NM, WA. Data for several states include expenditures for Medicaid Upper Payment Limit (UPL) programs or provider taxes.

- a. Data are for fee-for-service payments to mental health facilities and do not include services provided through managed care organizations; an additional \$2.7 billion in disproportionate share hospital payments, not reflected in the payment data above, was provided to mental health facilities.
- b. Data are for fee-for-services payments for rehabilitative services and do not include services provided through managed care organizations.

Medicaid Alternative Benefit Plans

As an alternative to states providing all of the mandatory and selected optional benefits under “traditional” Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established benchmark and benchmark-equivalent coverage, now referred to as “alternative benefit plans” (ABPs).²⁹ Under this optional state plan authority, states may enroll certain Medicaid subpopulations into benchmark benefit plans that include four choices: (1) the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program, (2) a plan offered to state employees, (3) the largest commercial health maintenance organization in the state, and (4) other coverage appropriate for the targeted population, subject to approval by the HHS Secretary. Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans identified above.³⁰ In general, these benefit packages look more like benefit coverage available in the private market and may cover fewer benefits than traditional Medicaid. Under the “other” HHS Secretary approved option, states may choose to cover certain LTSS. For

²⁹ For more information, see CRS Report R42478, *Traditional Versus Benchmark Benefits Under Medicaid*, by Elicia J. Herz.

³⁰ Benchmark-equivalent coverage must also include (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) emergency care; (5) well-child care, including immunizations; (6) prescribed drugs; (7) mental health services; and (8) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the applicable benchmark plan for vision care and hearing services (if any).

example, some states have used the ABP authority to cover personal assistance services, home health, and care coordination for adults with disabilities.³¹ The ACA requires all Medicaid ABPs to cover essential health benefits (EHBs), as a minimum floor of coverage. Coverage of EHBs also applies to plans offered in the health insurance exchanges established under the ACA.

Since the enactment of the ACA, Medicaid ABPs have taken on a new importance with implications for coverage of certain LTSS. A new group of non-elderly, non-pregnant adults with income up to 133% of the federal poverty level (FPL) will be eligible for Medicaid beginning in 2014, or sooner, at state option. Certain individuals with disabilities may be among those newly eligible for the Medicaid program.³² This new eligibility group will receive Medicaid coverage through ABPs which must include EHBs. The following describes several ways that states must cover or may choose to cover LTSS under ABPs.

Among the 10 broad EHB benefit categories is “rehabilitative and habilitative services and devices.” Prior to enactment of the ACA, states could cover rehabilitation as an optional state plan benefit and/or waiver service, and habilitation as a waiver service. In other words, there was no prior coverage mandate under Medicaid for these services. Coverage of rehabilitative and habilitative services must be included in ABPs. Such coverage is based on those services that are in the applicable base benchmark plan. If rehabilitative and habilitative services are not in the base benchmark plan or if commercial market coverage is not adequate, then the state will define rehabilitative and habilitative services.³³ While the CMS final rule does not establish a standard definition for such services, the rule suggests that states adopt service definitions similar to those issued by the National Association of Insurance Commissioners (NAIC) as follows.³⁴

- **Rehabilitative services and devices:** services and devices to assist a person to prevent deterioration and regain or maintain a skill or function acquired and then lost or impaired due to illness, injury, or disabling conditions.
- **Habilitative services and devices:** services and devices provided to a person to prevent deterioration and regain or maintain a skill or function never learned or acquired due to a disabling condition.

For example, rehabilitative and habilitative services may include physical and occupational therapy, speech-language pathology, audiology, and other services for persons with disabilities in a variety of inpatient and outpatient settings.

³¹ Specific groups are exempt from mandatory enrollment in ABPs (e.g., those with special health care needs such as disabling mental disorders or serious and complex medical conditions).

³² Individuals that are exempt from mandatory enrollment in ABPs will have a choice between ABP benefits as defined by the state under Section 1937 of the SSA and ABP benefits defined as the state’s approved Medicaid state plan benefits that are not subject to the requirements of Section 1937 (i.e., these benefits do not have to meet the EHB coverage minimums, but may include LTSS services included in the state plan). Thus, states can offer another way to provide LTSS for individuals with disabilities who are eligible for Medicaid through the ACA expansion group, or through another Medicaid eligibility group that receives coverage through the ABP state plan option. (Department of Health and Human Services, “Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges, Eligibility and Enrollment; Final Rule,” *78 Federal Register* 42160, July 15, 2013, p. 42193; Department of Health and Human Services, “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,” *78 Federal Register* 12834, February 25, 2013.

³³ *78 Federal Register* 42160, July 15, 2013, p. 42193.

³⁴ *Ibid.*, p. 42214.

States may choose to substitute in LTSS benefits with current EHB offerings in a base benchmark plan or supplement current EHB offerings with additional benefits, including state plan optional LTSS. With respect to the substitution policy, EHBs are first defined as the benefits from the base benchmark plan, supplemented with benefits from other base benchmark plans as necessary.³⁵ States may substitute benefit by benefit within the same EHB category as long as the benefits being exchanged are actuarially equivalent. For example, a state may choose to offer LTSS under the substitution policy by substituting an existing benchmark benefit under the EHB category “ambulatory patient services” with a personal care services benefit in designing their ABP to meet the minimum floor of coverage under the EHB requirements, maintaining actuarial equivalency.

In designing a Medicaid ABP, states may also choose the “other coverage” option, subject to approval by the HHS Secretary, to offer LTSS within an ABP. In doing so, states may choose to offer “traditional” Medicaid benefits, which may include the full range of optional state plan benefits, including any applicable LTSS benefits, as the ABP, as long as these benefit packages meet EHB requirements.

States that choose to extend Medicaid eligibility to individuals in the expansion group may begin coverage on January 1, 2014. For those states, information about covered benefits offered through ABPs, and any LTSS offerings within those plans, is not yet publicly available.³⁶

State Plan HCBS Option (Section 1915(i) of SSA)

Section 1915(i) of the SSA allows states to offer a broad range of HCBS under the Medicaid state plan. States that choose this optional benefit can cover HCBS for certain eligible Medicaid beneficiaries without obtaining a Secretary-approved waiver for this purpose. However, eligible beneficiaries must meet specific financial and needs-based eligibility criteria for the state plan HCBS Option. To be eligible for the 1915(i) benefit, Medicaid beneficiaries’ incomes must be less than or equal to 150% of the federal poverty level (FPL, \$1,436 per month) for an individual in 2013.³⁷ In addition, they must have a level-of-care need that is less than the level of care required in an institution. States may extend eligibility for the 1915(i) benefit to beneficiaries with incomes up to 300% of the maximum Supplemental Security Income (SSI) benefit (\$2,130 per month for an individual in 2013)³⁸ for those eligible for HCBS services under home and community-based waiver programs.³⁹ For eligible beneficiaries who meet this higher financial eligibility threshold and waiver criteria, their level-of-care need may have to meet the level of care provided in an institution. States may also create a new Section 1915(i) eligibility pathway

³⁵ The 10 broad EHB categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care.

³⁶ As of September 30, 2013, the following states are moving forward with Medicaid expansion: AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NV, NJ, NM, NY, ND, OR, RI, VT, WA, and WV (CMS, *State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014*, <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>).

³⁷ CMS, “2013 Poverty Guidelines,” at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf>.

³⁸ SSA, “2013 Fact Sheet,” at <http://www.ssa.gov/pressoffice/factsheets/colafacts2013.htm>.

³⁹ Includes Medicaid waiver programs authorized under Section 1115 of the SSA or Sections 1915(c), (d) or (e) of the SSA.

into Medicaid to increase access to HCBS for individuals who need a lower level of care than is provided in an institution. States may extend full Medicaid benefits to this new eligibility group.

The HCBS state plan option allows states to tailor different benefit packages to certain groups of beneficiaries. States can make this option available to specific populations and can vary the benefit package, as well as the amount, duration or scope of the benefits for each of these populations. Such elections are for five-year periods (i.e., an initial five-year period and subsequent five-year renewal periods). States must offer benefit packages statewide and may not cap the number of beneficiaries receiving state plan HCBS. To help states manage enrollment, Medicaid law allows states to modify their needs-based criteria without obtaining prior approval from the HHS Secretary.

In the design of each benefit package, states may choose from the same list of services offered under a Section 1915(c) HCBS waiver program (see **Table 3** under “Section 1915(c) HCBS Waivers” for a general description of these services). The list includes services such as case management, home-maker/home health aide, personal care, adult day health, habilitation, and respite care. For individuals with chronic mental illness states may provide day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Similar to Section 1915(c) waivers, states have the ability to name and define Section 1915(i) services, as well as identify and define other services, subject to HHS Secretary approval. This flexibility has led to state variation in naming conventions and service definitions across HCBS state plan and waiver services.

In addition, states may seek HHS Secretary approval to offer other services, with the exception of room and board. Section 1915(i) services must be provided in a home and community-based setting; however, regulations establishing a standard definition for such setting have yet to be finalized.⁴⁰ For FY2011, Medicaid expenditures for Section 1915(i) services were \$8.4 billion.⁴¹ As of November 2013, 12 states participate in the 1915(i) state plan HCBS option; another 4 states had either submitted an application to CMS or were otherwise in the planning process.⁴² In many cases, states taking up the option reported targeting services to persons with mental illness or intellectual disabilities.

Community First Choice Option (Section 1915(k) of SSA)

Section 1915(k) of the SSA, the Community First Choice (CFC) Option, allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and receive an increased FMAP rate of 6 percentage points for doing so.⁴³ Eligible beneficiaries

⁴⁰ See footnote 9.

⁴¹ Eiken, S., K. Sredl, L. Gold, et al., *Medicaid Expenditures for Long-Term Services and Supports in 2011*, Truven Health Analytics, June 2013.

⁴² The following states participate in the Section 1915(i) option: CA, CO, CT, FL, IA, ID, LA, MT, NC, NV, OR, and WI. Another four states are in the planning process: DE, IN, MD, MN. For more information, see the National Associations of State Units on Aging and Disability (NASUAD), *State Medicaid Integration Tracker, October-November 2013 Edition, November 15, 2013*, at <http://www.nasuad.org/sites/nasuad/files/20131115%20October-November%202013%20Integration%20Tracker.pdf>.

⁴³ CMS issued a final rule on the CFC Option, see Department of Health and Human Services, “Medicaid Program; Community First Choice; Proposed Rule,” 77 *Federal Register* 26362-26406, May 7, 2012. The rule did not finalize requirements regarding CFC settings which have been proposed in a separate rule, 77 *Federal Register* 26367, published May 3, 2012.

include those who are (1) eligible for medical assistance under the state plan and (2) in an eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet institutional level-of-care criteria to be eligible for CFC services.⁴⁴ States must provide these services on a statewide basis and in the most integrated community-based setting in which individuals with disabilities interact with non-disabled individuals.

Community-based attendant services and supports include attendant services and supports to assist eligible individuals in accomplishing ADLs, IADLs, and health-related tasks. Such services must be delivered under a person-centered plan of care in which attendants are selected, managed, and dismissed by the recipient (or his or her representative). Attendants must be qualified to deliver such services and may include family members (as defined by the HHS Secretary). This state plan benefit may also fund transition expenses when a beneficiary moves from a nursing facility to a community-based setting. Such expenses might include security deposits for an apartment or utilities, bedding, and basic kitchen supplies, among other expenses necessary to accomplish the transition. Additionally, states may provide services that increase independence or substitute for human assistance, such as non-medical transportation or purchasing a microwave oven.⁴⁵

Additional requirements for states who offer the CFC optional benefit include (1) collaborating with a state-established Development and Implementation Council; (2) establishing and maintaining a comprehensive, continuous quality assurance system; and (3) collecting and reporting information for federal oversight and evaluation. In the first full fiscal year in which the state plan benefit is implemented, states must maintain or exceed the preceding fiscal year's Medicaid expenditures for individuals with disabilities or elderly individuals. As of November 2013, two states received approval from CMS to offer the CFC option; another eight states had either submitted an application to CMS or were otherwise in the planning process.⁴⁶

Home and Community Care for Functionally Disabled Elderly Individuals (Section 1929 of SSA)

Section 1929 of the SSA allows states to provide home and community care services for Medicaid beneficiaries, aged 65 or over, who are determined to be functionally disabled and are eligible for Medicaid coverage.⁴⁷ Eligible beneficiaries can only receive covered home and community care benefits and are not eligible for full Medicaid state plan benefits. Services must be furnished in accordance with an individual community care plan that is reviewed and revised by a qualified community care case manager. Under this authority, states may cover one or more of the following services: homemaker/home health aide services, chore services, personal care, nursing care, respite care, training for family members in managing the individual's care, and

⁴⁴ Ibid., p. 26837.

⁴⁵ Ibid., p. 26828.

⁴⁶ CA and OR received CMS approval for the CFC Option. AR, CO, LA, MD, MN, MT, NY, and TX were in the planning process. For more information, see the National Associations of State Units on Aging and Disability (NASUAD), *State Medicaid Integration Tracker, October-November 2013 Edition*, November 15, 2013, at <http://www.nasuad.org/sites/nasuad/files/20131115%20October-November%202013%20Integration%20Tracker.pdf>.

⁴⁷ Generally, states are not permitted to apply the more liberal financial standards that states may use for persons served under Section 1915(c) waiver programs (i.e., 300 percent of the SSI benefit) unless they discontinue their waiver programs and provide coverage to such waiver participants under this new optional benefit.

adult day care. For individuals with chronic mental illness, states may cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services. States may waive the “statewideness” requirement under this section. States may also cover other services approved by the HHS Secretary, with the exception of room and board. Federal matching payments to participating states may not exceed 50% of the aggregate amount that would have been spent to provide Medicare skilled nursing facility services to persons receiving home and community care. Federal matching payments can also be reduced if the state fails to maintain levels of certain nonfederal expenditures. Texas offers personal care services under Section 1929 and as of 2010 is the only state that uses this Medicaid statutory authority.⁴⁸

Table 2 compares key features of selected options states have to provide HCBS under Medicaid. Section 1915(c) waivers are discussed in greater detail under the section entitled “Medicaid Waivers.” These HCBS options are illustrative of the variation that exists within the Medicaid program for covering LTSS. Thus, while states may offer the same services, whether these services are offered as state plan or waiver services may determine whether all Medicaid beneficiaries have access to these services statewide or to a specific geographic area.

In addition, states that choose to offer HCBS under either the Section 1915(c) waiver or Section 1915(i) HCBS state plan authority have discretion in determining the HCBS benefit package, including the service type and definition. Thus, states may use different terms to refer to the same types of service, and similarly named services may be defined differently across waiver programs within a state as well as across states. For example, states may refer to personal care services as personal attendant services, personal assistance services, or attendant care services. This program-level variation makes it difficult to summarize and compare state Medicaid HCBS offerings both within a state and nationally.

Table 2. Key Features of Selected Options for Covering HCBS Under Medicaid

Feature	Optional HCBS State Plan Benefits	Sec. 1915(c) HCBS Waiver	Sec. 1915(i) HCBS State Plan Benefits	Sec. 1915(k) Community First Choice State Plan Benefits
Benefit Eligibility	States must provide services to all categorically eligible individuals who are enrolled in Medicaid and meet the needs-based criteria	States can target services to specific populations (e.g., age and diagnosis) who meet the needs-based criteria, and can limit the number of people served	States can target services to specific populations (e.g., age and diagnosis), but must provide services to all individuals in an eligibility group who meet the applicable financial and needs-based criteria	States must provide services to all individuals who are enrolled in Medicaid in an eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet the needs-based criteria

⁴⁸ Eiken, S., K. Sredl, B. Burwell, et al., Medicaid Expenditures for Long-Term Services and Supports: 2011 Update, Thomson Reuters, October 31, 2011.

Feature	Optional HCBS State Plan Benefits	Sec. 1915(c) HCBS Waiver	Sec. 1915(i) HCBS State Plan Benefits	Sec. 1915(k) Community First Choice State Plan Benefits
Geographic Criteria	Services must be available statewide	Services can be limited to certain geographic area(s)	Services must be available statewide	Services must be available statewide
Needs-Based Eligibility Criteria	Beneficiaries must have functional limitations that result in the need for covered services, as specified by the state	Beneficiaries must meet institutional level-of-care criteria	Beneficiaries must meet needs-based criteria that are less stringent than institutional level-of-care criteria Beneficiaries eligible for certain approved waiver programs with income that does not exceed 300% of the maximum SSI income eligibility standard may also have to meet institutional level-of-care criteria	Beneficiaries must meet institutional level-of-care criteria
Coverable Services	Only federally specified services for each of the following: personal care, case management, and rehabilitation	A broad array of state-defined services, some of which are specified in federal statute, such as adult day health, case management, habilitation, homemaker, home health aide, personal care, respite care, and other Secretary approved services ^a	Same as Section 1915(c) HCBS waiver	Coverage includes personal care attendant services and supports and may include transition costs (e.g., first month's rent, utilities) and services that improve independence or substitute for human assistance, such as non-medical transportation services
Permits Payment of Relatives	Relatives who are not legally responsible may provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services under specific circumstances as determined by the state	Same as Section 1915(c) HCBS waiver	Same as Section 1915(c) HCBS waiver
FMAP Rate	Regular state FMAP rate	Regular state FMAP rate	Regular state FMAP rate	6% enhanced state FMAP rate ^b
Subject to Renewal	No	Yes, initial term of three years, renewable for five-year periods	Yes, renewable every five years	No

Source: CRS analysis, adapted from HHS, *Understanding Medicaid Home and Community-Services: A Primer*, 2010, Table 4-2, pg. 110.

Notes: Personal care services are also referred to as personal attendant services, personal assistance services, or attendant care services. FMAP refers to the federal medical assistance percentage, which determines the federal share for most Medicaid service costs.

- a. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).
- b. The Section 1915(k) CFC enhanced FMAP rate is the state's regular FMAP rate plus 6 percentage points.

Medicaid Waivers

Medicaid law also provides the HHS Secretary with authority to offer a broad range of home and community-based services (HCBS) to individuals with disabilities of all ages under Medicaid “waiver” programs. The term Medicaid “waiver” is so-named because states may request that the HHS Secretary waive certain statutory requirements that would normally apply to services covered under their Medicaid state plans. The most common waiver authority states use to provide HCBS to Medicaid beneficiaries is the Section 1915(c) waiver authority, named for the section of Medicaid law in which it is authorized. Individuals served under Section 1915(c) waiver programs live in a community-based setting but require the level of care offered in an institution. Some states also use the waiver authority under SSA Section 1115, Research and Demonstration Projects, to cover HCBS. These waiver options are described in greater detail below.

Section 1915(c) Home and Community-Based Services Waivers

Section 1915(c) waivers, often referred to as HCBS waivers, and are designed to expand opportunities for states to provide home and community-based care to additional groups of persons with LTSS needs while containing costs. Under this authority, states with approved applications may provide home and community-based care to persons who, without these services, would require Medicaid-covered institutional care. Section 1915(c) waivers permit states to cover services that go beyond the medical and medically related benefits that have been the principal focus of the Medicaid program. Under this authority, states can cover a wide variety of nonmedical, social, and supportive services that allow individuals to live independently in the community.

The Medicaid statute specifies a broad range of services that states may provide to waiver participants. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, rehabilitation, and respite care. States also have flexibility to offer additional services when approved by the HHS Secretary. For the chronically mentally ill, Section 1915(c) authorizes states to cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Section 1915(c) waivers may *not* cover room and board in a community-based setting, such as an assisted living facility.

For a general description of the types of services covered under Section 1915(c) waivers, see **Table 3**. Note that states have the ability to name and define Section 1915(c) waiver services, as well as identify and define other services subject to HHS Secretary approval. Thus, there is tremendous state-to-state variation in naming conventions and service definitions across Section 1915(c) waiver programs.

Table 3. Covered Medicaid Services Under Section 1915(c) Home and Community-Based Services (HCBS) Waiver Programs

Service	General Service Description
Adult Day Health	Services furnished on a regularly scheduled basis for four or more hours per day, one or more days per week, in a non-institutional, community-based setting that encompasses both health and social services needed to ensure the optimal functioning of the individual.
Case management	Services that assist individuals in gaining access to needed waiver and other state plan benefits, as well as needed medical, social, educational and other services, regardless of the funding source.
Habilitation	Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary for individuals to reside successfully in home and community-based settings. May include the following types of habilitation: residential habilitation, day habilitation, certain prevocational services, certain educational services, and supportive employment services.
Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage such activities.
Home Health Aide ^a	Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved state plan or are provided when home health aide services furnished under the approved state plan limits are exhausted.
Personal Care ^b	Services to assist with activities of daily living (ADLs) such as eating, bathing, dressing, and personal hygiene. May include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores which are incidental to the care furnished, or which are essential to the health and welfare of the individual.
Respite Care	Services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care.
Other (Secretary approved)	Other specified services under the waiver program may include home modifications, skilled nursing services, non-medical transportation, specialized medical equipment and supplies, personal emergency response systems, adult foster care, and assisted living services, among others.

Source: Section 1915(c) HCBS Waiver Application Instructions, Appendix C: Participant Services, at <http://157.199.113.99/WMS/help/35/appInstrSecC.html>. Covered services are those listed in Section 1915(c)(4)(B) of the SSA. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

- a. Home health services are a mandatory state plan service. Home health aide services are a component of the state plan coverage. In a waiver, a state may elect to furnish home health aide services that are different in their scope and nature than the services offered under the state plan.
- b. Personal care services are an optional benefit that a state may furnish under its state plan, as provided in 42 CFR §440.167. A state may offer personal care under a waiver when (a) it does not offer personal care under its state plan; (b) its coverage under the waiver differs in scope and nature from the coverage under the state plan; or (c) the state wishes to furnish personal care services in an amount, duration, or frequency that exceeds the limits in the state plan.

States must target a 1915(c) waiver to a specific population, such as individuals under age 65 with physical disabilities, individuals with intellectual or developmental disabilities, individuals with HIV/AIDS, individuals ages 65 and older, or individuals with mental illness. As a result, states often have more than one approved Section 1915(c) waiver, with each waiver program offering a

specialized package of HCBS to a specific population. Eligible waiver participants must meet certain financial requirements (including income and resource requirements) and state-defined level-of-care criteria that demonstrate the need for LTSS. That is, individuals must have a level of need for LTSS that would otherwise be covered under a Medicaid institutional benefit, such as nursing facility care, Intermediate Care Facility for the Mentally Retarded (ICF/MR), or hospital care.

Under Section 1915(c), the HHS Secretary has the authority to waive Medicaid's "statewide" requirement to allow states to offer HCBS in a limited geographic area. The HHS Secretary may also waive the "comparability" requirement that services be comparable in amount, duration, or scope for individuals in particular eligibility categories. States may use the Section 1915(c) waiver to limit the number of individuals served by capping enrollment. The Section 1915(c) waiver is time limited and waiver approvals are subject to reporting and evaluation requirements. State-approved Section 1915(c) waivers must also meet a "cost-neutrality" test where average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. States may also use cost-containment strategies in addition to the federally mandated cost neutrality requirement, such as fixed expenditure caps either applied to individual participants or in aggregate as well as service limitations.⁴⁹ Expenditures under these waivers are matched at the state's regular FMAP rate.

In 2009, more than 1.3 million Medicaid beneficiaries were receiving services under Section 1915(c) HCBS waivers.⁵⁰ Forty-eight states and DC offer at least one Section 1915(c) HCBS waiver, with states offering multiple waivers targeting HCBS to different groups. Nationwide, there were 289 Section 1915(c) HCBS waivers active in 2009.^{51,52} For FY2011, Medicaid expenditures for Section 1915(c) HCBS waivers were \$38.0 billion.⁵³ The majority of waiver participants target the aged and disabled populations (47%), followed by waivers for individuals with intellectual and developmental disabilities (I/DD, 42%), with the remaining 11% targeting other populations such as children with special needs, and individuals with traumatic brain injuries, HIV/AIDS, and mental health needs.⁵⁴

⁴⁹ Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2009 Data Update*, December 2012.

⁵⁰ Ibid.

⁵¹ Ibid. AZ and VT do not offer Section 1915(c) HCBS waivers and instead operate their entire Medicaid LTSS programs under Section 1115 demonstration waiver programs.

⁵² CMS has issued two proposed rules regarding Medicaid 1915(c) HCBS waivers. (1) "Medicaid Program; Home and Community-Based Services (HCBS) Waivers," 76 *Federal Register* 21311-21317, April 15, 2011. This proposed rule would revise regulations by providing states the option to combine certain waivers targeting groups; convey expectations about person-centered plans of care; provide characteristics of settings that are not HCBS; and describe additional strategies available to CMS to ensure state compliance. (2) "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule," 77 *Federal Register* 26367, May 3, 2012. This proposed rule would amend regulations consistent with other requirements under the ACA to provide authority for a five-year duration for certain demonstration and waiver programs, including the Section 1915(c) waiver program, at the discretion of the HHS Secretary when these programs involve those dually eligible for Medicaid and Medicare.

⁵³ Eiken, S., K. Sredl, L. Gold, et al., *Medicaid Expenditures for Long-Term Services and Supports in 2011*, Truven Health Analytics, June 2013.

⁵⁴ Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2009 Data Update*, December 2012.

In addition, states may combine an HCBS waiver with the Section 1915(b) waiver authority to provide HCBS to targeted populations in a managed care arrangement or within a limited pool of providers; these waivers are sometimes referred to as concurrent Section 1915(b)/1915(c) waivers. Under Section 1915(b), the HHS Secretary has the authority to waive the “freedom of choice” of provider requirements, among other requirements, in order to mandate enrollment in managed care plans that provide HCBS. States must apply for each waiver authority concurrently and comply with the individual requirements of each waiver authority. States also must comply with the separate reporting requirements for each waiver. Because each waiver is approved for a different period of time, requests for renewal by the state must be prepared and submitted at different points in time. As of July 2011, there were 13 concurrent Section 1915(b)/(c) waivers operating in 10 states.⁵⁵

Section 1915(d) HCBS Waivers for the Elderly

States may provide comprehensive HCBS to elderly persons at risk of needing nursing home care under Section 1915(d) Medicaid waiver authority. Like Section 1915(c) HCBS waivers, states may waive the Medicaid statewideness and comparability requirements to target services to individuals whom they believe can be served effectively in the community. States can provide case management, homemaker/home health aide services, personal care, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and that also facilitate their ability to reside in the community.

Section 1915(d) waiver authority differs from the Section 1915(c) HCBS authority in two respects. First, the target population is limited to persons 65 years of age and older who, without HCBS, would require nursing home care that would be paid for by Medicaid. Second, Section 1915(d) establishes a cap or ceiling on the total amount that states may spend for Medicaid institutional and HCBS for individuals age 65 and older. As of May 2012, no state had elected to provide services under Section 1915(d) HCBS waiver authority.⁵⁶

Section 1915(e) HCBS Waivers for Certain Children

States may cover HCBS for certain children infected with HIV/AIDS or who are drug dependent at birth. Under Section 1915(e) authority, states may provide services to such children under age 5 who are receiving or are expected to receive federally funded adoption or foster care assistance. Also, it must be determined that the child requires the level of care provided by a hospital or nursing facility. Like Section 1915(c) HCBS waivers, states are authorized to waive the Medicaid statewideness and comparability requirements. Services that states may provide under this waiver program include nursing care, physician services, respite care, prescription drugs, medical devices and supplies, transportation, and any other service requested by the state and approved by the HHS Secretary. Similar to Section 1915(c) waivers, Section 1915(e) waivers must meet a “cost-neutrality” test. As of May 2012, no state had elected to provide services under Section 1915(e) HCBS waiver authority.⁵⁷

⁵⁵ List of waivers obtained from the Centers for Medicare & Medicaid Services, Office of Legislation, July 2011.

⁵⁶ Centers for Medicare & Medicaid Services, “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule,” 77 *Federal Register* 26367, May 3, 2012.

⁵⁷ Ibid.

Section 1115 Research and Demonstration Projects

Section 1115 provides the HHS Secretary with broad authority to waive certain statutory requirements, thus allowing states to conduct research and demonstration projects under several programs authorized by the SSA, including Medicaid. Under Section 1115, the HHS Secretary may waive Medicaid requirements contained in Section 1902 of the SSA including, but not limited to, “freedom of choice” of provider, “comparability” of services, and “statewide-ness.” The HHS Secretary may also use Section 1115 waiver authority to provide federal funds for costs that are not otherwise matched under Section 1903 of the SSA.⁵⁸ States must submit proposals outlining terms and conditions for proposed waivers to CMS and receive approval before implementing these programs.

Expenditures under approved Section 1115 waivers are financed through federal and state matching funds at the regular FMAP rate. However, unlike traditional Medicaid, costs associated with Section 1115 waiver programs must be “budget neutral” to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state’s existing Medicaid program. For example, costs associated with an expanded population (e.g., those not otherwise eligible under Medicaid), must be offset by spending reductions elsewhere within the Medicaid program. Several methods are used by states to generate cost savings for such waivers such as (1) limiting benefit packages for certain eligibility groups; (2) providing targeted services to certain individuals so as to divert them from full Medicaid coverage; and (3) using enrollment caps and beneficiary cost-sharing to reduce the amounts states must pay. Section 1115 waivers are time limited and approvals are subject to reporting and evaluation requirements.⁵⁹

Some states use Section 1115 waivers, either in addition to or in lieu of Section 1915(c) HCBS waivers, to provide HCBS to targeted populations. Compared to Section 1915(c) HCBS waivers, the use of Section 1115 waivers offers states some additional flexibilities in the design of the HCBS benefit package, the organization of payments for services, and/or the delivery of care. For example, some states have used Section 1115 waivers to provide HCBS services to beneficiaries under managed care. Other states have used such waivers to allow beneficiaries to self-direct their LTSS by providing them with an individual budget to directly purchase services and hire legally responsible family members (e.g., spouse or parent) to provide care. A state may obtain approval for these practices and a variety of other self-directed activities under a Section 1115 waiver, including (1) changing the Medicaid eligibility requirements (e.g., allowing an individual to have more income and still qualify for Medicaid); or (2) waiving the requirement that the state only pay those agencies, or practitioners, that have provider agreements with the state.

As of 2012, three states (Arizona, Rhode Island, and Vermont) use Section 1115 waivers to administer statewide Medicaid programs that include HCBS instead of Section 1915(c) HCBS waivers. Five states (Delaware, Hawaii, New York, Tennessee, and Texas) use Section 1115 waivers for Medicaid managed care programs that include HCBS for certain populations and/or specific geographic areas in their states. These states also use Section 1915(c) HCBS waivers for

⁵⁸ Section 1903 describes the conditions under which federal financial participation is available. Section 1115(a)(2) stipulates that expenditures under a waiver are eligible for matching under Section 1903.

⁵⁹ Section 1115 waiver projects are generally approved for a five-year period, however, states may seek up to a three-year extension for their existing waiver program. The approval process associated with each type of extension is defined in statute at Section 1115(e) and at Section 1115(f), respectively.

other home and community-based services.⁶⁰ For FY2011, Medicaid expenditures for HCBS authorized under Section 1115 were \$1.5 billion.⁶¹

Other Medicaid HCBS Authorities and Financing Incentives

Other federal Medicaid statutory authorities also authorize states to provide certain HCBS to eligible individuals, such as the Program for All-Inclusive Care of the Elderly (PACE). Congress has also enacted grant and demonstration projects that provide states with financial incentives to expand access to HCBS through their Medicaid LTSS delivery systems while decreasing coverage of institutional care, such as the Money Follows the Person and Balancing Incentives Payment, which are described below.

Program for All-Inclusive Care of the Elderly (PACE)

To improve the delivery of HCBS and to reduce institutionalization among individuals enrolled in both Medicaid and Medicare (i.e., dual eligibles) with LTSS needs, Congress authorized the Program for All-Inclusive Care of the Elderly (PACE) as a demonstration program in 1986.⁶² The Balanced Budget Act of 1997 (P.L. 105-33) established PACE as a permanent program under both Medicaid and Medicare. PACE is a voluntary Medicaid and Medicare integration program for dual-eligible beneficiaries with LTSS needs who receive services in adult day health centers. PACE providers receive capitated payments from both Medicaid and Medicare to provide a comprehensive package of covered benefits to individuals age 55 and older who require the level of care offered in a nursing home. PACE providers assume the risk for expenditures that exceed their capitation payments. States may elect to provide PACE services to eligible individuals under an agreement with the PACE provider, HHS Secretary, and the state Medicaid agency.

Covered services include primary care, hospital care, medical specialty services, prescription drugs, nursing home care, emergency services, home care, physical and occupational therapy, adult day care, recreational therapy, meals, dentistry, nutritional counseling, social services, and transportation, among others. Under PACE, an interdisciplinary team of physicians, nurses, physical therapists, social workers, and other professionals provide all needed health, medical, and social services, primarily in adult day care settings with in-home and referral services based on beneficiary needs. The goal is to provide seamless coordinated care to certain low-income individuals aged 55 and older who would otherwise require nursing home care.⁶³ As of 2012, 88

⁶⁰ Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2009 Data Update*, December 2012.

⁶¹ Eiken, S., K. Sredl, L. Gold, et al., *Medicaid Expenditures for Long-Term Services and Supports in 2011*, Truven Health Analytics, June 2013. Also includes Medicaid HCBS expenditures under the Section 1915(a) managed care waiver authority.

⁶² Further discussion of integrated care models for dual eligibles is beyond the scope of this report.

⁶³ CMS, Program for All-Inclusive Care of the Elderly (PACE), at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html>.

PACE programs were operational in 29 states.⁶⁴ For FY2011, Medicaid expenditures for PACE programs totaled \$912 million.⁶⁵

Money Follows the Person (MFP) Rebalancing Demonstration

Section 6071 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) established the Money Follows the Person (MFP) Rebalancing Demonstration grant program, which appropriated \$1.75 billion in funding through FY2011 for states to transition current institutionalized individuals into community residential settings with the goal of increasing the use of Medicaid HCBS. The ACA extended the MFP Rebalancing Demonstration for an additional five years, through September 30, 2016, and appropriated an additional \$2.25 billion (\$450 million for each of FYs 2012 through 2016).^{66,67} The MFP Rebalancing Demonstration is administered by CMS.

Under the MFP Rebalancing Demonstration, the HHS Secretary is authorized to award competitive grants to states to meet the following statutory objectives:⁶⁸

- **Rebalancing**—Increase the use of home and community-based care, rather than institutional, long-term care services.
- **Money follows the person**—Eliminate barriers or mechanisms, whether in the state law, the state Medicaid plan, the state budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.
- **Continuity of service**—Increase the ability of state Medicaid programs to assure continued provision of HCBS to eligible individuals who choose to transition from an institutional to a community setting.
- **Quality assurance and quality improvement**—Ensure that procedures are in place (at least comparable to those required under the applicable HCBS program) to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

To receive an MFP grant, an eligible state must submit an application to CMS for approval. Among other requirements, individuals eligible to participate in the MFP Rebalancing Demonstration must be (1) a resident in an inpatient facility in which they have been residing in for not less than 90 consecutive days; (2) receiving Medicaid benefits for inpatient services

⁶⁴ National PACE Association, at http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_is_PACE? accessed August 1, 2013.

⁶⁵ Eiken, S., K. Sredl, L. Gold, et al., *Medicaid Expenditures for Long-Term Services and Supports in 2011*, Truven Health Analytics, June 2013.

⁶⁶ Any funds remaining at the end of each fiscal year carry over into the next fiscal year, and can be used by CMS to make grant awards to current and new grantees until FY2016. Grant awards are available to states for the fiscal year in which they received the award, and 4 additional fiscal years. Thus, any unused grant funds awarded in FY2016 can be used until FY2020.

⁶⁷ Sec. 2403 of the ACA also expanded eligibility by reducing the length of stay requirement in an inpatient facility from at least six months to at least 90 consecutive days. This provision also removed the maximum length of stay of not more than two years in an inpatient setting.

⁶⁸ Sec. 6071(a)(1)-(4) of the DRA.

furnished by such an inpatient facility; and (3) continuing to require the level of care provided in an inpatient facility. Medicare-covered short-term rehabilitative services are excluded from counting toward the 90-day durational period. For each eligible beneficiary who is transitioned from an institution to the qualified community-based setting during the demonstration period, the MFP Rebalancing Demonstration provides the state Medicaid program an increased FMAP rate for 12 months.⁶⁹ After this period, the state must continue to provide HCBS for as long as the beneficiary is Medicaid eligible and needs community-based services.

In 2007, CMS awarded over \$1.4 billion in grant funding to 30 states and DC.⁷⁰ As of March 2013, an additional 16 states were awarded MFP Rebalancing Demonstration grants for a total of 47 state grantees. Among these grant recipients, 36 states and DC had implemented demonstration programs; 5 states were in the program planning stage; 3 states were in the process of implementation; one state had an inactive program; and another state rescinded its grant.⁷¹ According to Mathematica Policy Research, after five full years of implementation (January 2008 to December 2012), just over 30,000 individuals were enrolled in the MFP Rebalancing Demonstration and received assistance to move from institutional settings into the community.⁷²

Balancing Incentive Payments Program

The ACA also established the four-year Balancing Incentive Payments (BIP) Program.⁷³ The BIP Program authorizes CMS to provide incentive payment grants to qualifying state Medicaid programs for increasing their share of LTSS spending on HCBS while reducing their spending on LTSS institutional care. To be eligible to receive payments, states must have spent less than 50% of total Medicaid medical assistance spending on non-institutionally based LTSS for FY2009. Specifically, if states spent less than 25% on non-institutionally based LTSS in FY2009, states must achieve a 25% target on HCBS by October 1, 2015, in order to receive bonus payments. Such states will receive an FMAP rate increase of 5 percentage points on eligible medical assistance payments. States that spent at least 25% but less than 50% on non-institutionally based LTSS in FY2009 will be required to reach a target of 50% by October 1, 2015, to qualify for payments. These states will receive an FMAP rate increase of 2 percentage points for eligible payments. The aggregate amount of payments made by the HHS Secretary under the BIP program to states must not exceed \$3 billion over the BIP period which began October 1, 2011, and ends on September 30, 2015.

To receive incentive payments, a state must submit an application to CMS for approval that meets programmatic and structural reform requirements and achieves the target spending percentage

⁶⁹ The enhanced FMAP rate available under the MFP Rebalancing Demonstration is equal to the state's regular FMAP rate, subtracted from 100 percent, divided in half, and added to the regular FMAP rate. The maximum enhanced FMAP rate available under the demonstration is 90%.

⁷⁰ CMS, Money Follows the Person (MFP) Rebalancing Demonstration Fact Sheet, June 2007, at http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/MFP_FactSheet.pdf.

⁷¹ Susan R. Williams, Debra Lipson, Noelle Denny-Brown, et al., "Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2012," July 2013, at http://www.mathematica-mpr.com/publications/pdfs/health/mfp_july-dec2012_progress.pdf; In addition to DC, the 36 states with active MFP include AR, CA, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MO, MS, NC, ND, NE, NH, NJ, NV, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI; 5 states in the planning stages for MFP include AL, CO, MT, SC, and SD; 3 states in the implementation stages were FL, MN, and WV; OR's program is inactive; and NM rescinded its grant.

⁷² Ibid., p. 2.

⁷³ Sec. 10202 of the ACA.

applicable to the state. For states proposing to expand the Section 1915(i) HCBS option, the application must include a description of the state's election to increase the eligibility level above 150% of the FPL (\$1,436 per month for an individual in 2013)⁷⁴ to a percentage not exceeding 300% of the SSI benefit rate (\$2,130 per month in 2013 for an individual).⁷⁵ The application must include a description of the new or expanded offering of those services that the state will provide and the projected costs of such services. To qualify for incentive payments, states may not apply more restrictive eligibility standards, methodologies, or procedures than were in effect on December 31, 2010. In addition, states must agree to use additional incentive payments for new or expanded offerings of HCBS services under Medicaid.⁷⁶ States must also collect data from providers and others on services, quality, and outcomes.

Further, states must agree to implement the following structural changes:

- **No wrong-door single entry point system**—a statewide system enabling consumers to access all LTSS through an agency, organization, coordinated network, or portal that provides information regarding the availability of such services, how to apply for such services, referral services for LTSS available in the community, and determinations of financial and functional eligibility for LTSS, or assistance with assessment processes for financial and functional eligibility.
- **Conflict-free case management services**—services to develop a service plan, arrange for LTSS, support the beneficiary (and, if appropriate, the caregiver) in directing his or her services and supports, and conduct ongoing monitoring to assure that services and supports delivered to the beneficiary meet his or her needs and achieve intended outcomes.
- **Core standardized assessment**—development of instruments for determining eligibility for non-institutionally based LTSS, uniformly used across the state, to determine the beneficiary's need for training, support services, medical care, transportation, and other services, and to develop an individual service plan.

CMS identified 38 states as eligible for the BIP program. However, states are also permitted to provide CMS with additional information on their Medicaid LTSS expenditures for FY2009 for the purposes of determining BIP Program eligibility.⁷⁷ According to CMS, the following 16 states have approved BIP applications as of August 2013: Arkansas, Connecticut, Georgia, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, New Hampshire, New Jersey, New York, Ohio, and Texas.⁷⁸

⁷⁴ CMS, "2013 Poverty Guidelines," at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf>.

⁷⁵ SSA, "2013 Fact Sheet," at <http://www.ssa.gov/pressoffice/factsheets/colafacts2013.htm>.

⁷⁶ The increased FMAP rate is applicable to expenditures for HCBS provided under several Medicaid authorities, including (a) the home health care and personal care state plan benefits, (b) Section 1915(c) HCBS waivers, (c) Section 1915(i) HCBS state plan option, and (d) Section 1915(k) CFC state plan option. According to CMS, the enhanced FMAP rate available under the BIP can be added to the enhanced FMAP rate available under CFC but not Money Follows the Person (Source: GAO, *Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services*, GAO-12-649, June 2012, p. 13, footnote 23, <http://www.gao.gov/assets/600/591560.pdf>).

⁷⁷ GAO, *Medicaid: States' Plans to Pursue New and Revised Options for Home- and Community-Based Services*, GAO-12-649, June 2012, p. 13, footnote 22, <http://www.gao.gov/assets/600/591560.pdf>.

⁷⁸ CMS, *Balancing Incentive Program*, at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/> (continued...)

Appendix. Legislative History of Medicaid Long-Term Services and Supports (LTSS)

Prior to the enactment of Medicaid in 1965, homes for the aged and other public institutions were financed by a combination of direct payments made by individuals from their Old Age Assistance benefits,⁷⁹ and vendor payments made by states with federal matching payments on behalf of individuals. The Kerr-Mills Medical Assistance to the Aged program enacted in 1960 (P.L. 86-778) allowed states to provide medical services, including skilled nursing care, to persons who were not eligible for Old Age Assistance cash payments, thereby expanding the covered population.

In 1965, when Kerr-Mills was incorporated into the new federal-state Medicaid program, Congress created an entitlement to skilled nursing facility care for beneficiaries age 21 and older, requiring all states to offer this service under the expanded program.⁸⁰ It also gave skilled nursing facility care the same priority status as hospital and physician services. Subsequent amendments allowed states to provide care in “intermediate care facilities” for persons who did not need skilled nursing facility care, but needed assistance beyond room and board alone.⁸¹ In 1987, Congress eliminated the distinction between skilled nursing facilities and intermediate care facilities (effective in 1990) in the Medicaid program. Medicaid law now refers collectively to these facilities as nursing facilities.⁸²

These early legislative developments helped stimulate growth in the nursing home industry. A significant increase in the number of nursing homes was seen from 1960 to 1970. Over that time period the number of nursing homes more than doubled, from around 9,600 to almost 23,000, and the number of beds more than tripled from 331,000 to more than 1 million.⁸³ Since 1970, the count of nursing homes nationwide has declined, but the number of beds has increased. For example, in 2011, the total number of nursing homes nationwide totaled 15,700 while the number of beds totaled 1.7 million.⁸⁴

Home care services also received some congressional attention in Medicaid’s original authorizing statute. Under the 1965 law, home health care was established as one of the optional services that states could provide. In 1968, three years after Medicaid was established, Congress amended the law to require states to provide home health care to persons entitled to skilled nursing facility care as part of their state Medicaid plans (effective in 1970).⁸⁵ Over time, states were authorized to

(...continued)

Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html, accessed August 1, 2013.

⁷⁹ Old Age Assistance gave cash payments to poor elderly. This was the original version of Social Security benefits established under Title I of the Social Security Act in 1935 (P.L. 74-271).

⁸⁰ Social Security Amendments of 1965 (P.L. 89-97).

⁸¹ Act of December 14, 1971 (P.L. 92-223).

⁸² Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

⁸³ U.S. Congress, Senate Special Committee on Aging, *Developments in Aging, 1970*, Report 92-46, Feb. 16, 1970, Washington, p. 42, cited from the American Nursing Home Association Fact Book, 1969-1970.

⁸⁴ National Center for Health Statistics, *Health, United States, 2012: With Special Feature on Emergency Care*, Hyattsville, MD, Table 109, <http://www.cdc.gov/nchs/data/abus/abus12.pdf#109>.

⁸⁵ Social Security Amendments of 1967 (P.L. 90-248), effective July, 1970.

cover other types of home and community-based services (HCBS) as optional benefits under the Medicaid state plan. For example, the optional personal care benefit was first available in 1978.⁸⁶ To enable states to make improvements in the management of care for their LTSS beneficiaries and other groups, Congress added an optional case management benefit in 1986.⁸⁷

Medicaid Home and Community-Based Waivers

During the 1970s, the former Department of Health, Education and Welfare (HEW) devoted increased attention to alternatives to nursing home care through a variety of federal research and demonstration efforts.⁸⁸ These efforts were undertaken not only to find ways to offset the high cost of nursing facility care, but also to respond to the desires of persons with disabilities to remain in their homes and in community-based settings, rather than in institutions. However, it was not until 1981 that Congress took significant legislative action to expand HCBS when it authorized the Medicaid Section 1915(c) Home and Community-Based Waiver Program.⁸⁹

Congress established the 1915(c) waiver program in response to general concerns about the lack of federal funding for home and community-based care. The waiver program was also intended to respond to specific concerns that Medicaid provided far greater support for nursing facility care than home and community-based care. Prior to 1981, many of the non-skilled personal care and supportive services needed by chronically impaired persons to remain in the community were not covered under Medicaid. With approved waiver programs, states were authorized to cover a wide variety of nonmedical, social, and supportive services designed to assist individuals with independent living.

Congress also authorized the Program for All-Inclusive Care for the Elderly (PACE), as a demonstration program, in 1983 to improve the delivery of HCBS and to reduce institutionalization among the dual eligibles (i.e., those eligible for both Medicaid and Medicare) age 55 and older with LTC needs.⁹⁰ The Balanced Budget Act of 1997 (P.L. 105-33) established PACE as a permanent option under both Medicaid and Medicare.

The Olmstead Decision

In 1999, the U.S. Supreme Court ruled on a landmark case for individuals with disabilities, *Olmstead v. L.C.*⁹¹ The Court held that institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA).⁹²

⁸⁶ Provided in federal regulation (43 *Federal Register* 45228, September 29, 1978). Congress then added personal care to the list of services specified in the Medicaid statute under the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

⁸⁷ Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272), effective April, 1986.

⁸⁸ U.S. General Accounting Office, *Home Health Care Benefit Under Medicare and Medicaid*, July 9, 1974, <http://archive.gao.gov/f0302/094820.pdf>.

⁸⁹ Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

⁹⁰ Social Security Act Amendments of 1983 (P.L. 98-21).

⁹¹ 527 U.S. 581 (1999).

⁹² Specifically, the Court held that the Americans with Disabilities Act (ADA) requires states to transfer individuals with mental disabilities from institutions to less confining community settings when a state treatment professional has determined the latter is appropriate, the community setting is not opposed by the individual with a disability, and the placement can be reasonably accommodated by the state. A January 2000 Health Care Financing Administration (now continued...)

This case prompted federal administrative and legislative activities to encourage efforts to provide expanded HCBS to persons with disabilities. Since this time, every state has taken up either the Section 1915(c) HCBS waiver program option or a comparable waiver under the authority of Section 1115 of the SSA, to offer HCBS to certain LTSS beneficiaries. To assist states in Medicaid LTSS delivery system transformation toward HCBS, in FY2001 Congress first appropriated funding for the Real Choice Systems Change Grants for Community Living Program. Since then, CMS awarded over 350 grants to states between FY2001 and FY2010 for a total of approximately \$288.6 million.⁹³

The Deficit Reduction Act

Under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), Congress established two optional state plan Medicaid benefits that allow states to cover certain HCBS for eligible beneficiaries.⁹⁴ One option gives states the authority to cover a new waiver-like HCBS state plan option (i.e., Section 1915(i) of the SSA) without requiring a Secretary-approved waiver for this purpose. Under this option, states may offer selected benefit packages to targeted populations so as to delay and/or prevent the need for institutional care. The second state plan option, under Section 1915(j) of the SSA, provides states the authority to offer consumer-directed personal care services with features such as individual budgets and the ability to purchase non-traditional goods and services. Among other things, these options incorporated certain elements that had previously only been allowed under Medicaid waivers, giving states greater flexibility to offer HCBS while targeting benefits to certain populations which may assist states in controlling related spending. The DRA also established the Money Follows the Person (MFP) Program, a demonstration grant program to provide assistance to eligible Medicaid beneficiaries who want to move from institutional settings—such as nursing homes—back to their homes or other community residential settings.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided a number of new options under Medicaid for states to further efforts to increase coverage of HCBS. First, the ACA added the Community First Choice (CFC) Option, a new authority under Section 1915(k) of the SSA, which authorizes states to offer personal care attendant services, among other services. States that choose this option will receive an increased FMAP rate of 6 percentage points. The ACA also expanded the Section 1915(i) HCBS state plan option established under the DRA. Among other changes, the ACA increased the amount of income individuals may have to qualify for the benefit and added new flexibility for states to target different benefit packages to specific populations with LTSS needs. In addition, ACA expanded the list of services states may

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Centers for Medicare & Medicaid Services) notice to state Medicaid directors indicated that the decision was applicable to all individuals with disabilities, not just those with mental disabilities.

⁹³ CMS, *Real Choice Systems Change Grant Program*, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Real-Choice-Systems-Change-Grant-Program-RCSC/Real-Choice-Systems-Change-Grant-Program-RCSC.html>, accessed August 19, 2013.

⁹⁴ In addition, the DRA established new grants to help expand adult day care services into rural areas under the Program for All-Inclusive Care for the Elderly (PACE), an integrated Medicaid and Medicare program, and authorized additional grant funding to states to conduct demonstration projects to increase the use of and expand states' capacity to provide HCBS.

cover to include state-selected services, other than room and board, that are approved by the HHS Secretary, which is similar to Section 1915(c) HCBS waiver programs. The ACA also granted states the option to establish a new Medicaid eligibility pathway for certain qualifying beneficiaries who meet the Section 1915(i) benefit's financial and needs-based criteria. Finally, the ACA established a four-year incentive payment program, referred to as the Balancing Incentive Payments (BIP) Program, and extended the Money Follows the Person (MFP) demonstration through 2016 by providing additional funding to support the original state grantees and to award grants to additional states.

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