Medicaid 101

Long-Term Services and Supports

Claudia Schlosberg, J.D.

Castle Hill Consulting, LLC

202-486-0822

Email: CastleHConsulting@gmail.com

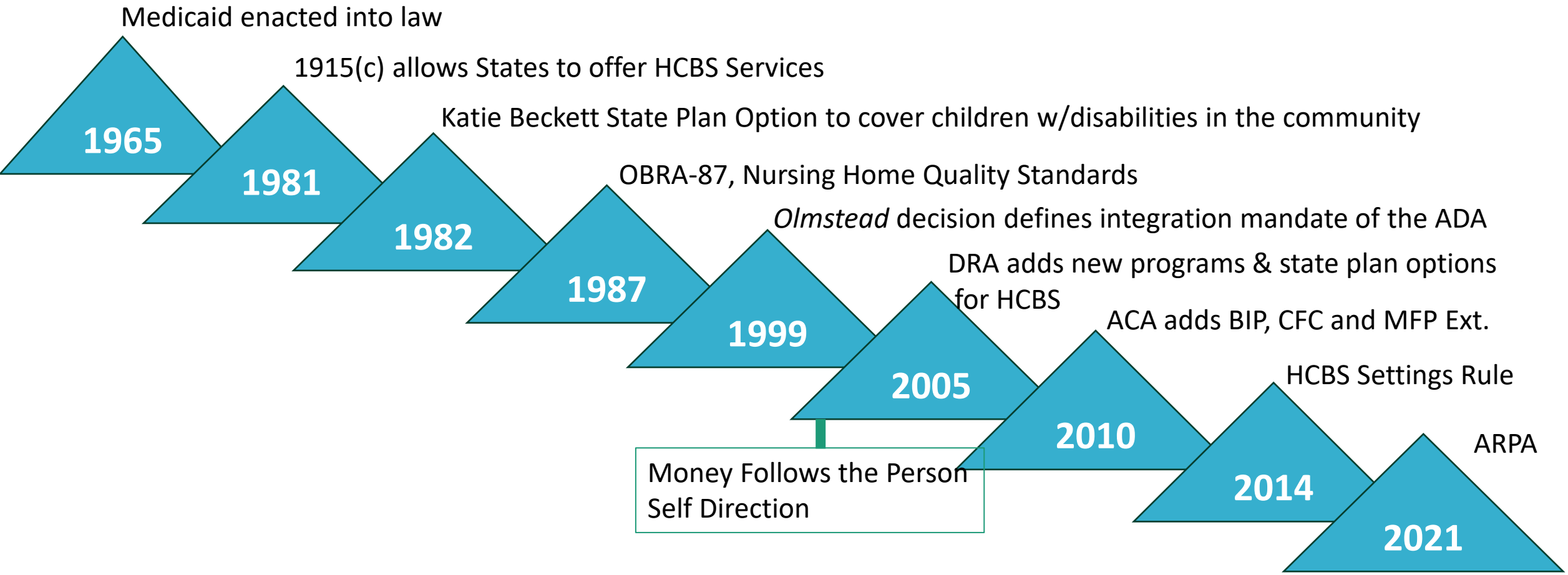
AGENDA

- **Historical Perspective**
- **Medicaid's Role in LTSS**
- **Institutional and Home and Community-based benefits**
- ***Olmstead v. LC* and the Evolution of Home and Community-Based Services**
- **Authorities: State Plan Amendments, Waivers and Demonstrations**
- **Vestiges of Institutional Bias**
- **Challenges and Opportunities**

Historical Perspective

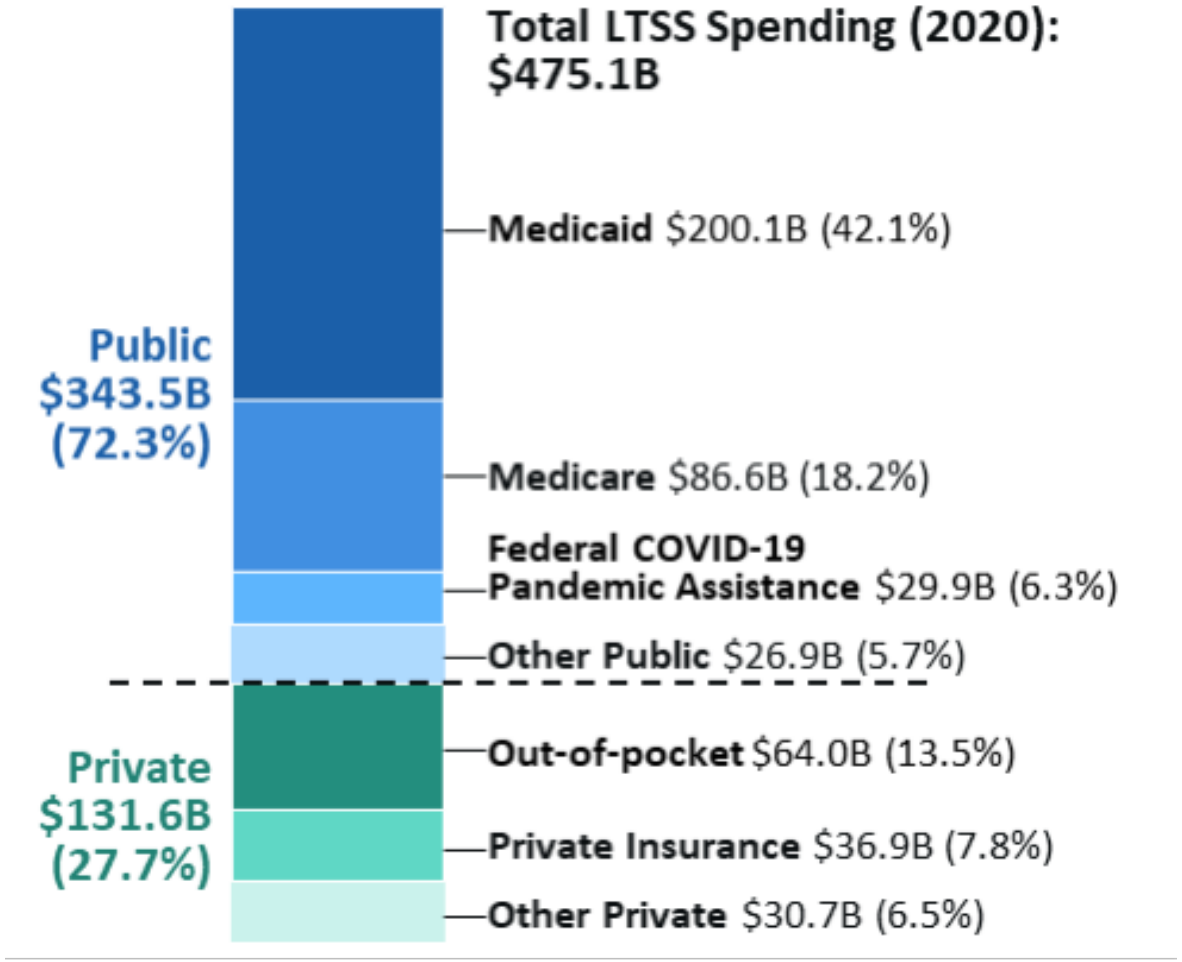
- Medicare and Medicaid became law on July 30,1965 under Title XVIII and XIX of the Social Security Act after decades of struggle to create a national health insurance program in the USA.
- No national consensus on national health insurance.
- Strong, organized opposition from factions that believe national health insurance was “ant-American,.” both Medicare and Medicaid reflected compromises made through the political process.
- Medicare provided health insurance coverage to individuals age 65+ and older.
    - Part A covered in-patient hospital bills.
    - Part B, which was voluntary , covered physician visits and other ancilliary services.
    - No drug benefit or long- term care benefit.
- Medicaid covered health insurance for specific categories of very low-income individuals:
    - Children ,
    - Pregnant women , and
    - Families with dependent children on welfare.
    - No coverage for childless adults, and
    - No long-term care except in institutions.

Medicaid LTSS Coverage Timeline



Medicaid is the single largest payor for Long-Term Care

LTSS by Spending by Payor, 2020



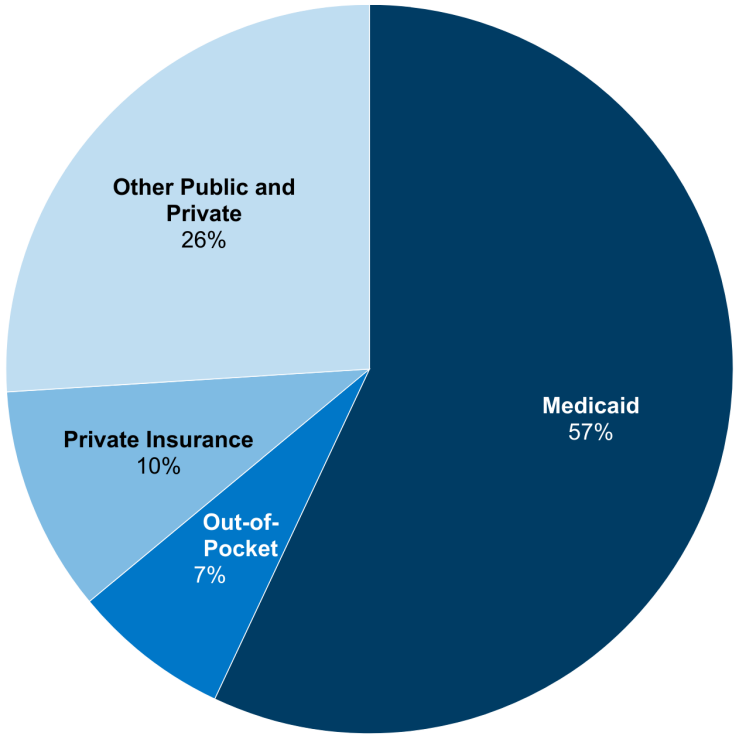
Source: Who pays for Long Term Services and Supports, Congressional Research Services, June 15, 2022, accessed on August 1, 2023, https://crsreports.congress.gov/product/pdf/IF/IF10343

Medicaid Pays for Nearly 60% of HCBS LTSS

Figure 1

Home and Community-Based Services (HCBS) spending, by payer, 2020.

Total National HCBS Spending: $286.5 billion



NOTE: Total HCBS expenditures include spending on residential care facilities, home health care services, and home and community-based waiver services. Expenditures also include spending on ambulance services. This chart does not include Medicare spending on home and community-based post-acute care ($46 billion in 2020). All home and community-based waiver services are attributed to Medicaid.
SOURCE: KFF estimates based on 2020 National Health Expenditure Accounts data from CMS, Office of the Actuary.

KFF

Source: Medicaid Home & Community-Based Services: People Served and Spending During COVID-19, March 4, 2022

6

Medicaid LTSS includes both Institutional and Home and Community-Based Services

Institutional Services -Mandatory

***Inpatient Hospital**
***Nursing Facility**

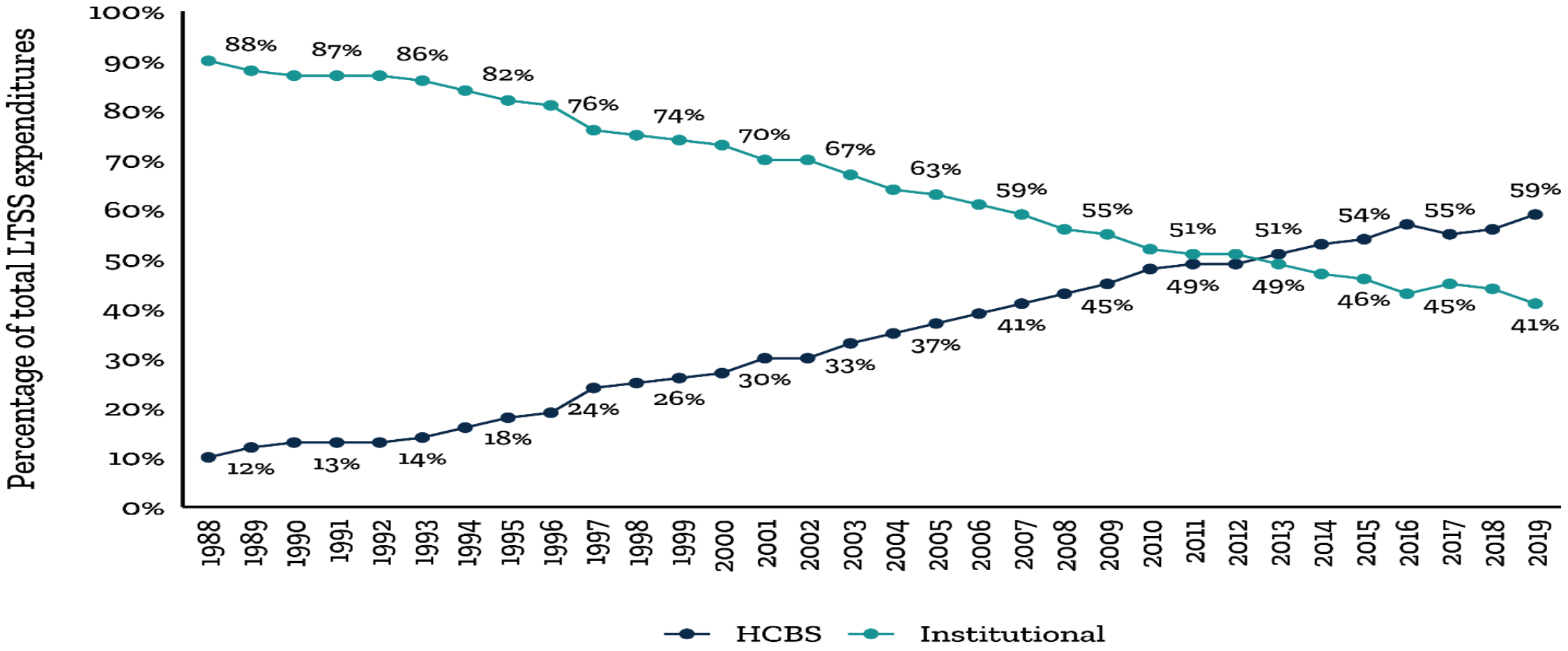
HCBS Services - Optional

*Personal Care Assistance *Case Management *Home Modifications
*Personal Emergency Response Systems *Family Support & Training* Respite Care
* Assisted Living *Home Delivered or Congregate Care Meals *Home Health Services
*Home Safety Assessments * Supported and Shared Living * Supported Employment * Pre-vocational Training *Assistive Devices and Supplies *Transition Assistance
*Consumer-directed Care * Homemaker and Chore Service *Crisis services *Transportation
*Behavioral Supports. *Diet and Nutrition Services

The Impact of the ADA and *Olmstead V. L.C.,* 527 U.S. 581 (1999)

- **1990 – Americans with Disabilities Act (ADA), Title II, prohibits public entities from discriminating against individuals with disabilities in the provision of public services.**
- **"Integration Regulation" – Requires public entities to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities. (28 CFR 35.130(d))**
- **Public entities further must make "reasonable modifications" to avoid discrimination based upon disability.**
- **In *Olmstead*, affirmed that unjustified isolation is properly regarded as discrimination based upon disability. States *must* place persons with disabilities in community settings rather in in institutions:**
  - **When the States treating professionals have determined that community placement if appropriate,**
  - **The transfer is not opposed by the affected individual, and**
  - **The placement can be reasonably accommodated, taking into account the resources available to State and the needs of others with mental disabilities.**

Medicaid HCBS and Institutional LTSS Expenditures as a Percent of Total Medicaid LTSS expenditures, FY 1988 to 2019



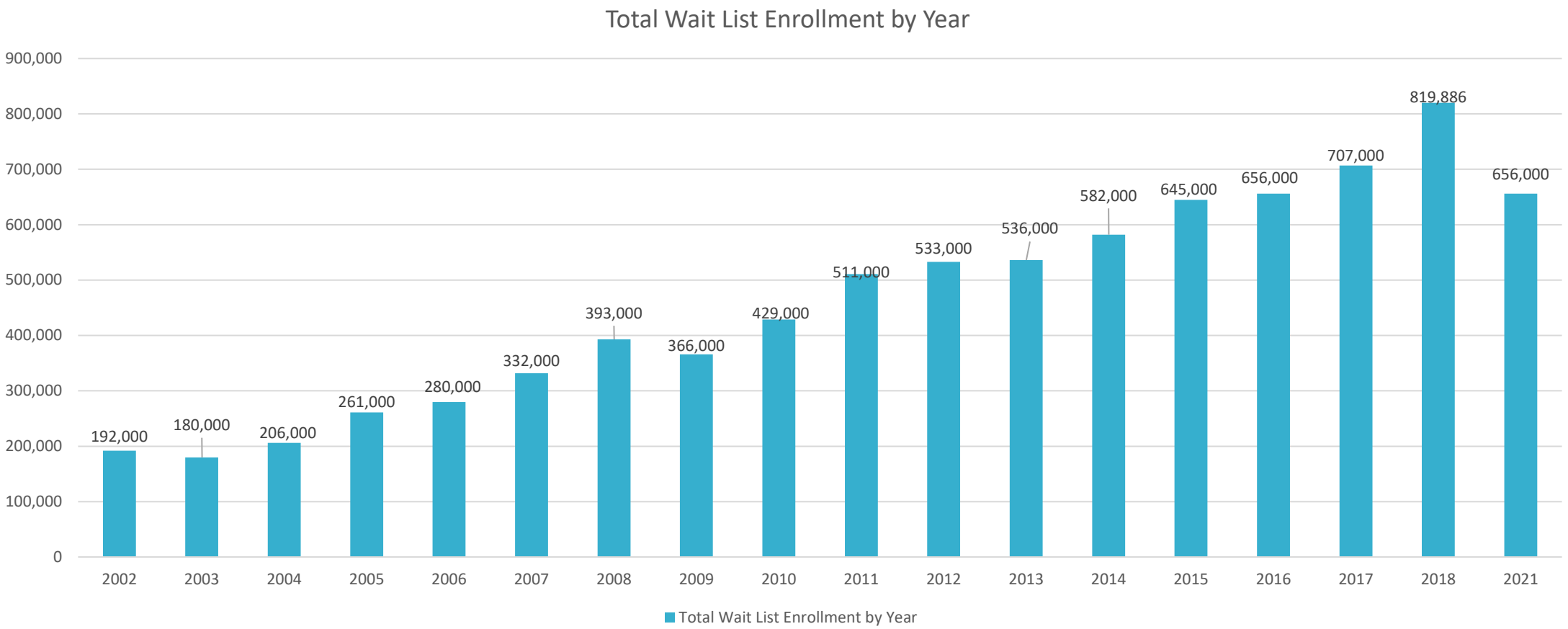
Source: CMS Report, https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf, accessed on August 1, 2023

While CMS continues to focus national policy on community integration and consumer choice, vestiges of "Institutional Bias" in Medicaid remain.

Institutional Long-Term Care	Home and Community-based Long-Term Care
Mandatory	**Optional**
Enrollment is not capped	**In most programs, enrollment is capped, creating waiting lists**
Pays for Room and Board	**Prohibits payment for Room and Board**
Spend Down – Uses projected expenses	**Spend down – Uses incurred expenses***
Reimbursement method is often a per diem bundled payment	**Reimbursement is often based upon units of services, i.e., 15 minutes.**
	In most programs, need to demonstrate cost neutrality
	In most programs, individual must meet nursing facility level of care
Nursing homes are inherently institutional – Cannot co-locate HCBS services in an institutional setting.	

*New CMS policy and a proposed rule may help mitigate the institutional bias of spend down rules.

Growth in Medicaid HCBS Waiting List Enrollment 2002 – 2021



Source: Kaiser Family Foundation, Medicaid HCBS Program Surveys, 2002-2018; Kaiser Family Foundation, "A Look at Waiting Lists for Home and Community-based Services from 2016 to 2021, Nov. 8, 2022, available at: https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/

Key Concepts in Understanding State Authority to "Draw Down" Federal Medicaid Dollars to Pay for Services that Support HCBS Services

- **Medicaid State Plan** – Operational Agreement between Federal Government and State that gives State authority to draw down federal match for approved services.
- **Waivers** – Allows Federal Government to exempt States from specific Medicaid statutory requirements, i.e., comparability, statewideness, choice, or are approved for research and demonstration purposes
- **Federal Financial Participation or FFP** - The federal share of Medicaid spending.
- **Federal Medical Assistance Percentage or FMAP** – The formula used to determine the amount of a State's FFP. It is based upon the average per capital income for each State relative to the national average.
  - FMAP cannot be lower the 50%.
  - Some programs and services are eligible for enhanced FMAP rates.

  -- FMAP for Administrative activities is capped at 50%.

For every State dollar spent on an allowable service, the federal government will match it at the State's FMAP rate.

State plan benefits that include HCBS	HCBS authorities	Research and demonstration programs	Integrated care programs	Managed long term services and supports (MLTSS)	Medicaid administrative activities
• Home health • Personal care services • Case management and targeted case management • Section 1945 Health Home	• Section 1915(c) • Section 1915(i) • Section 1915(j) self-directed personal care services • Section 1915(k) Community First Choice	• Section 1115 demonstrations • Money Follows the Person (MFP) demonstration	• Programs for All-Inclusive Care for the Elderly (PACE) • Accountable care organizations (ACOs) • Integrated care for people dually eligible for Medicare and Medicaid	• Including those authorized under Section 1915(a) or 1915(b) waivers	• Partnership development • Data and information technology

Medicaid Benefits and Programs that Support Community-based Services

- CMS LTSS Toolkit: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

1915(c) Home and Community Based Services Waiver

Who can be served?

- Individuals who require an institutional level of care (hospital, nursing facility or ICF/ID).
- Are a member of a target group that is included in the waiver. (States may include multiple target groups in a single waiver).
- Meet applicable financial eligibility criteria.
- Require one or more waiver services in order function in the community, and
- Exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care
- State must specify the unduplicated number of individuals to be served.

1915(c) Home and Community Based Services Waiver

What Services can be Offered?

- State may offer services enumerated in the statute or propose other services that assist individuals to remain in the community – there are no required services.
- Waiver services compliment State Plan Services; a waiver participant must have full access to State Plan Services.
- States can offer extended State Plan Services that exceed the limits that apply under a State Plan.
- There is no limit to the number of services that a state may offer in a waiver.
- States may not claim Federal Match (FFP) for Room and Board

1915(c) HCBS Waivers Assurances

States must assure CMS that HCBS Waiver programs will:

- Be cost neutral (cannot cost the federal government more than providing services in an institution).
- Protect the health and safety of individuals in the program.
- Provide adequate and reasonable provider standards to meet the needs of individuals served in the waiver.
- Ensure that services follow an individualized and person-center plan of care.
- Develop and implement a quality improvement strategy.
- Comply with HCBS settings rule requirements.

A Note on Cost Neutrality

- States must ensure that the average per capita expenditure under the waiver does not exceed 100 percent of the average per capital expenditures that would have been made had the waiver not been granted.
- Cost neutrality formula looks at total Medicaid costs, not just waiver costs.
- Formula: D+D' Compared to G+G'

  Factor D – Per Capita Medicaid Cost for HCBS Services

  Factor D' – Per Capita Medicaid cost for all other services provided to Waiver Participants

  Factor G – Per capital Medicaid cost for NF or ICF/ID care

  Factor G'- Per Capita Medicaid Costs for all Services other than those in G

Section 1115 Research & Demonstration Waivers

- Give HHS Secretary broad authority to approve experimental, pilot or demonstration projects to promote the objectives of the Medicaid program.
- Demonstrations must be “cost neutral” to the Federal government meaning Federal Medicaid expenditures will not be more than Federal spending without the demonstration over the life of the project.
- Generally approved for an initial five-year period and can be extended an additional 3-5 years.
- Evaluation/Reporting requirements.
- Examples: (1) “Cash and Counseling” in 1990(S), lead to inclusion of Participant-Directed Services in 1915(c) Waivers which led to DRA, Section 1915(i), 1915(j) and later 1915(k).
  (2) Managed Care
  (3) Comprehensive SUD Services
  (4) Services to individuals not yet eligible for Medicaid LTSS
  (5) Pre-ACA – Services to Childless adults
  (6) Financial Alignment

1915(i) HCBS State Plan Option

- Does not require cost neutrality or an institutional level of care (LOC) – Eligibility based upon needs-based criteria ascertained through independent, individualized assessment.
- Targets one or more specific populations defined by age, diagnosis or Medicaid Eligibility Group.
- Eligibility: Individuals with Income up to 150% FPL (no resource test) or may include individuals with income up to 300% SSI but must be eligible for existing 1915(c) or demonstration.
- Can waive comparability, but not statewideness.
- Enrollment CAPS and Waiting lists are prohibited.
- Allows use of self-direction and presumptive payment.
- State must have and implement an HCBS quality improvement strategy.
- Examples of Services offered: Transitional Case Management Services, Assisted Living, Adult Day Health, Behavioral Supports, etc.

1915(i) Benefits and Challenges

Benefits	Challenges
Can fill gaps in Medicaid coverage for targeted populations including people with serious mental illness and/or SUD, people in transition from criminal justice system, children with special conditions such as autism	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
Can provide coverage for specific services: adult day health, self-direction, housing supports	For non-institutional LOC, income limit of 150% FPL adds administrative complexity and limits coverage (especially for children or working adults)
Allows state to tighten criteria for institutional care without tightening access to HCBS	Cannot phase-in or limit geographic reach due to requirement to implement statewide
	Viewed as administratively burdensome

1915(j) Self Directed Personal Care Attendant Services State Plan Option

- Permits Self-Direction for PCA services. At state option,
  - Legally responsible relatives (spouses/parents) may provide care and be paid.
  - Allows participants to manage a cash disbursement and/or purchase goods, services and supplies to support community living.
  - Use a discretionary amount of the budget to purchase items not otherwise listed in the budget.
- State may limit geographic area and cap the number of people who can enroll.
- Can include people already enrolled in 1915(c).

1915(k) Community First Choice State Plan Option

- Allows State to establish Personal Care Attendant or Participant Directed Care Program through State Plan Amendment for individuals with institutional LOC.
- State may provide transitional services to help individuals move from institutions to the community and services that increase independence including assistive technologies, medical supplies/equipment and home modifications.
- Provide 6% INCREASE in FMAP for services provided.
- Enrollment caps/waiting lists prohibited.
- Must be offered statewide, benefits must be comparable for all and participants must have freedom of choice (cannot target specific populations) .
- Can limit amount duration and scope provided limits are sufficient to achieve program purpose.
- Eligible individuals include individuals eligible for NF Services under the State plan or, if not in such an eligibility group, have income at or below 150% of FPL.
- Maintenance of effort (MOE) requirement for first 12 months.
- Mandatory data collection and reporting, quality assurance system and development and implementation Council.

1915(k) Benefits and Challenges

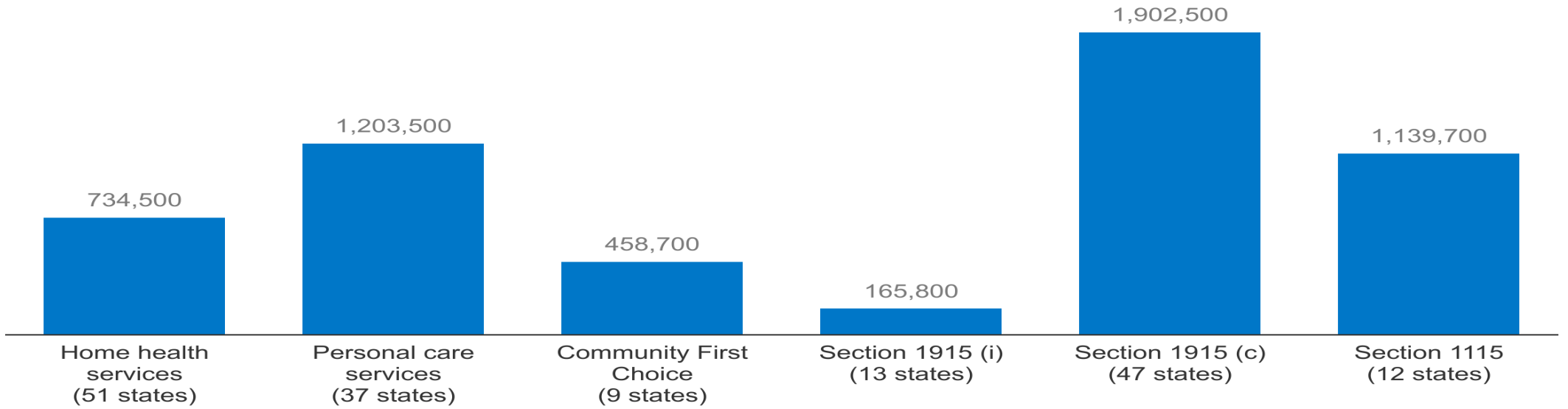
Benefits	Challenges
Increased FMAP	Increased FMAP not sufficient to cover new costs association with implementation, program expenditures and evaluation.
Allows states to consolidate programs and standardize eligibility and needs assessments	Does not eliminate need to maintain multiple HCBS programs
	Complex eligibility requirements
	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
	Viewed as administratively burdensome

Enrollment in HCBS Authorities

Figure 3

People receiving Medicaid HCBS by program authority, FY 2020.

State plan services include home health services (mandatory), personal care services, Community First Choice, and Section 1915 (i), collectively serving 2,562,500 people. Waivers include Section 1915 (c) and Section 1115, collectively serving 3,042,200 people.



NOTE: Home health omits AZ, DE, HI, and RI. Personal care omits DE, KS, NM, and RI. CFC omits NY. Section 1915 (i) omits AR. Section 1115 includes states with Section 1115 HCBS waivers without any accompanying Section 1915 (c) waivers.
SOURCE: KFF Medicaid HCBS Program Surveys, FY 2020.

KFF

Source: [Medicaid Home & Community-Based Services: People Served and Spending During COVID-19](), March 4, 2022

24

HCBS Program Design Considerations

- First, identify your goals and objectives.
- Second, identify the needs of the target population – claims analysis, historical spending, key informant interviews, stakeholder input, research into other state and payor practices.
- Third, identify the key design features that will help attain the goals and objectives.
- Design programs around those identified goals and objectives.
- Then, look to the authority that best supports what you hope to achieve.
- There is no right answer and there always will be trade-offs.

HCBS Final Rule. January 16, 2014

- Applies to 1915(C) waivers and 1915(I) and 1915(K) State Plan Options
- MLTSS/1115 Waiver States (i.e. Arizona) however, also have to comply.
- Designed to promote full access to benefits of community living in the most integrated setting appropriate.
- Mandates conflict-free assessments and case management services.
- Mandates a person-centered planning process and plan for services.
- Establishes mandatory requirements that define an HCBS setting.

HCBS Settings Rule

- General requirements focus on individual choice, autonomy and integration into the broader community.
- Additional requirements for Provider controlled settings
- Settings that are not HCBS include: Nursing Homes, IMDs, ICF/IDs and Hospitals
- Settings that are presumed not to be HCBS and subject to CMS heightened scrutiny review include:

  -Settings in a publicly or privately-owned facility providing inpatient treatment

  -Settings on grounds of, or adjacent to, a public institution

  -Settings with the effect of isolating individuals from the broader community of non-Medicaid individuals
- Settings that do not meet HCBS settings rule standards are not eligible for Medicaid payments.

HCBS Settings Rule

- STATE COMPLIANCE DEADLINE Final Compliance was extended one year to **March 17, 2023,** due to COVID.
- **Expectation:** All states and settings will be fully compliant with the following regulatory settings criteria that are not impacted by the COVID-19 PHE, including its exacerbation of the workforce shortage, by the end of the transition period.
- – Privacy, dignity, respect, and freedom from coercion and restraint; and control of personal resources.

  -- In provider-controlled settings– A lease or other legally enforceable agreement providing similar protections;
  – Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
  --Access to food at any time;
  – Access to visitors at any time;
  – Physical accessibility; and
  – Person-centered service plan documentation of modifications to relevant regulatory criteria.
- For those requirements that have been impacted by the pandemic, states can submit corrective action plans (CAPs) to allow settings more time to meet those requirements.
- According to ANCOR, 40 states requested CAPS

PHE Unwinding

- The Consolidated Appropriations Act, 2023, signed into law on December 29, 2022, delinked the continuous enrollment provision from the PHE, ending continuous enrollment on March 31, 2023. The CAA also phases down the enhanced federal Medicaid matching funds through December 2023.
- Biden declared an end to the PHE, effective March 11, 2023.
- Restart of Medicaid redeterminations of eligibility has placed beneficiaries at risk of losing coverage, most for procedural reasons.
- States are also returning to pre-pandemic policies and rolling back State flexibilities granted under various emergency/disaster relief authorities.
- Appendix K flexibilities will end November 11, 2023.
- Exception – If State has filed waiver amendments to incorporate flexibilities into the underlying waiver, flexibilities will be extended until new waiver is approved and effective to avoid lapse.

CMS Proposed Access Rule – published May 3, 2023

Attempt at comprehensive approach to improve access to care, quality and health equity, but heavy burden on states and providers

Acknowledges impact of low wages on access to care and quality.

Requires that 80% of all Medicaid payments to home health , PCAs and homemaker be spent on compensation to direct care workers, exclusive of training, admin., IT and supervisory costs. States must publish FFS payment rates including the average hourly rate by service category .

States must establish a Payment Rate Advisory Group.

New quality metrics for HCBS waivers focusing on annual reassessment of functional need and updates and revisions to the Person-centered Plan of Care.

Other requirements for greater transparency and participation in policy recommendations (MAC and BAG).

Challenges Ahead

- Steep reductions of eligibility could impact financial stability of safety net and other providers when faced with significant loss of revenue.
- Loss of ARPA funding, March 2025.
- Deepening workforce crisis in face of growing aging population.
- Renewed energy to impose work requirements as a condition of eligibility.
- Continued interest in eliminating the entitlement to Medicaid and reformulating the program as a block grant or payment based on per capita caps.

Additional Resources

CMS LTSS Toolkit: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf
CMS Waiver List – https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.htmL
CMS 1915(c) Waiver Technical Guidance – https://www.Medicaid.gov/Medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf
CMS Technical Assistance Webpage for HCBS – https://www.Medicaid.gov/Medicaid/hcbs/technical-assistance/index.html
CMS SPA and Waiver Processing page – https://www.Medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html
NASUAD, Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants, May 2018 - http://nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants_0.pdf
HSBS Settings: State Responses to COVID 19- https://www.medicaid.gov/medicaid/home-community-based-services/downloads/covid19-state-implications-reactions-innovations.pdf
Kaiser Family Foundation, Key State Policy Choices About Medicaid Home and Community-Based Services, Feb. 4, 2020, **https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-based-services-appendix-tables/**
Information on State ARPA Plans: **https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817-spending-plans-and-narratives/index.html**
Advancing States Analysis of States ARPA Spending Plans: http://www.advancingstates.org/slider/advancing-states-analysis-state-arpa-spending-plans
CMS unwinding and Returning to Regular Operations After the PHE, https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html.

Questions?