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Understanding Medicaid Home and Community Services:

A Primer



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

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Office of the Assistant Secretary for Planning and Evaluation

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**Understanding Medicaid
Home and Community Services: A Primer**

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Chapter 1

Medicaid Coverage of Home and Community Services: Overview

Long-term care includes a broad range of health and health-related services, personal care, social and supportive services, and individual supports. These services can be provided in institutions, an individual's home, or in community settings. This chapter recounts the legislative, regulatory, and policy history of Medicaid coverage of long-term care services and supports. Both institutional care and home and community services are described, with the latter in greater detail.¹

Introduction

Medicaid is a needs-based, entitlement program that is designed to help states meet the costs of necessary health care for low-income and medically needy populations. When a Medicaid State Plan is approved by the Centers for Medicare & Medicaid Services (CMS), states qualify to receive Federal matching funds to finance Medicaid services (see Box). States have substantial flexibility to design their programs within broad Federal requirements related to eligibility, services, program administration, and provider compensation.

Federal Medical Assistance Percentage (FMAP)

The Federal government's share of medical assistance expenditures under each state's Medicaid program, known as the Federal medical assistance percentage, is determined annually by a formula that compares the state's average per capita income level with the national average. States with higher per capita incomes are reimbursed smaller shares of their costs. By law, FMAP cannot be lower than 50 percent or higher than 83 percent. States are also reimbursed for 50 percent of administrative costs. For fiscal year 2009, the FMAP ranged from 50 percent in California and several other states to 75.84 percent in Mississippi.²

Program Evolution and Current Spending Allocations

When enacted, Medicaid was the medical care extension of Federally-funded programs providing cash assistance for the poor, with an emphasis on dependent children and their mothers, elderly persons, and persons with disabilities. Legislation in the 1980s expanded Medicaid coverage of low-income pregnant women and poor children, and extended coverage to some low-income Medicare beneficiaries who were not eligible for cash assistance. From its beginnings as a health care financing program primarily for welfare recipients, the Medicaid program has been amended and expanded to cover a wide range of populations and services.

When first enacted, Medicaid's main purpose was to cover primary and acute health care services, such as doctor visits and hospital stays. Mandatory coverage for long-term care was limited to skilled nursing facility (SNF) services for people age 21 or older. States were given the option to cover home health services and private duty nursing services. In response to the high costs of nursing facility care, combined with criticism of Medicaid's institutional bias, states and the Federal government began to look for ways to provide long-term care in less restrictive, more cost-effective ways. In 1970, home health services for those entitled to nursing home care became mandatory. Since that date, Medicaid has evolved into a program that allows states considerable flexibility to cover virtually all long-term care services and supports that people with disabilities need to live

independently in their homes and in a wide range of community residential care settings.

The Federal Medicaid statute (Title XIX of the Social Security Act) generally requires states to specify the amount, duration, and scope of each service they provide, which must be sufficient to reasonably achieve its purposes. States may not place limits on services or arbitrarily deny or reduce coverage of required services solely because of diagnosis, type of illness, or condition—called the comparability requirement.

Generally, a State Plan must be in effect throughout an entire state (i.e., the amount, duration, and scope of coverage must be the same statewide—called the “statewideness” requirement). The Social Security Act has some exceptions, notably (1) states operating Section (§)1915(c) home and community-based services (HCBS) waiver programs (hereafter called HCBS waiver programs) are permitted to target services by age and diagnosis and can offer them on a less than statewide basis, and (2) targeted case management services offered as an optional benefit under the State Plan are not subject to the statewideness requirement. (§1115 Research and Demonstration waivers can also operate on a less than statewide basis.)

By 1999, the year of the Olmstead decision, every state was providing home and community services under one or more of the available options except for §1915(i) (which did not become effective until 2007). By then, Medicaid had become the nation’s major public financing program for long-term care for low-income persons of all ages with all types of physical and mental disabilities.³

Since 1988, Medicaid spending for home and community services has increased dramatically. In that year, expenditures for all long-term care services totaled \$23 billion. Nearly 90 percent of those dollars paid for institutional services in nursing facilities and intermediate care facilities for persons with intellectual disabilities (ICFs/ID). Only 10 percent was spent on home and community services (i.e., HCBS waivers, personal care, home health, and targeted case management).⁴

In 2008, total Medicaid spending for all long-term care services had increased to \$106.4 billion. Institutional spending had dropped to 57.3 percent and HCBS spending increased to 42.7 percent. The latter percentage, however, masks large variations among states in the share of spending devoted to home and community services and among different populations. For example, in 2008 only 10 states spent 50 percent or more of their long-term care budgets on home and community services. New Mexico and Oregon ranked at the top with over 70 percent; Mississippi was at the bottom with 13.9 percent.⁵

Expansion of home and community services relative to institutional services has been particularly pronounced for individuals with intellectual disabilities and other developmental disabilities (ID/DD, hereafter called developmental disabilities). In 2008, only four states (New Mexico, Washington, Oregon, and California) spent more than 50 percent of their Medicaid long-term care budgets on home and community services for the aged and disabled population, while 42 states spent at least half of their Medicaid long-term care budgets on home and community services for individuals with developmental disabilities. As an example, Oregon’s spending on home and community services for the ID/DD population was 100 percent compared with 53.6 percent for the aged and disabled population.

Nationally, in 2008, 35.5 percent of Medicaid’s total long-term care expenditures for persons with developmental disabilities were allocated to institutional services and 64.5 percent to home and community services. The allocation for elderly persons and younger persons with physical disabilities was the opposite—68.4 percent of total long-term care expenditures for institutional services and 31.6 percent for home and community services.⁶

Major Features of Medicaid's Provisions for Home and Community Services

The remainder of this chapter presents a brief overview of the Medicaid law, regulations, and policies that give states the flexibility to create comprehensive home and community service systems for people of all ages with all types of physical and mental impairments and/or chronic health conditions. To provide context for the discussion, Table 1-1 lists the major relevant provisions of Medicaid law. This chronological summary illustrates the historical expansion of Medicaid long-term care services away from a primary focus on institutional care.

Key benefits for providing home and community services include both mandatory services such as Home Health and optional services such as Personal Care and Rehabilitation. Additional Medicaid provisions, such as the HCBS waiver authority, enable states to offer a comprehensive range of home and community services.

Mandatory State Plan Services: Home Health

Since 1970, services under the Home Health benefit have been mandatory for people entitled to nursing facility care.⁷ States are mandated to cover nursing home care for categorically eligible persons age 21 or older. This mandate entitles persons age 21 or older to nursing facility care. States have the option to cover nursing home care for other Medicaid beneficiaries as well, such as persons under age 21. If a state chooses to cover persons under age 21, they would also be entitled to nursing home care. However, being entitled to nursing home care does not mean that one is eligible for nursing home care. In order to receive Medicaid-covered nursing home care, entitled persons must also meet nursing home eligibility criteria—called level-of-care criteria.⁸ (See Chapter 3 for additional information about eligibility for services under the Home Health benefit.)

Federal regulations require that Home Health services include nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home. States have the option of

providing additional therapeutic services under the Home Health benefit—including physical therapy, occupational therapy, and speech pathology and audiology services.⁹ States may establish reasonable standards for determining the extent of such coverage using criteria based on medical necessity or utilization control.¹⁰ In doing so, a state must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service.¹¹ All Home Health services must be medically necessary and authorized by a physician's order as part of a written plan of care.

In 1998, following the ruling of the U.S. Court of Appeals for the Second Circuit in *DeSario v. Thomas*, CMS sent a letter to State Medicaid Directors clarifying that states may develop a list of pre-approved items of medical equipment as an administrative convenience but must provide a reasonable and meaningful procedure for beneficiaries to request items that do not appear on such a list.¹² Home Health services are defined in Federal regulation as services provided at an individual's place of residence. In 1997, however, the Federal Court of Appeals for the Second Circuit ruled in *Skubel v. Fuoroli* that home health nursing services may be provided outside the home, as long as they do not exceed the hours of nursing care that would have been provided in the home.¹³ (See Chapter 3 for additional information on this ruling.)

TABLE 1-1 Medicaid’s Legislative Provisions Regarding Long-Term Care Services

1965	Establishment of Medicaid ¹⁴ <ul style="list-style-type: none"> • Mandatory coverage of SNFs for categorically eligible persons age 21 or older. • Optional coverage of Home Health services and Rehabilitation services.
1967	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate for children under age 21. ¹⁵ States given the option to provide services not covered by their State Plans under EPSDT.
1970	Mandatory coverage of Home Health services for those entitled to SNF services. ¹⁶
1971	Optional coverage of intermediate care nursing facilities and ICFs/ID. ¹⁷
1972	Optional coverage of children under age 21 in psychiatric hospitals. ¹⁸
1973	Option to allow people receiving supplemental security income (SSI) to return to work and maintain their Medicaid benefits. ¹⁹
1981	Establishment of HCBS waiver authority. ²⁰
1982	Option to allow states to extend Medicaid coverage to certain children with disabilities who live at home but who, until this 1982 provision, were eligible for Medicaid only if they were in a hospital, nursing facility, or ICF/ID. Also known as the Katie Beckett or Tax Equity and Fiscal Responsibility Act (TEFRA) provision. ²¹
1986	Option to cover targeted case management (TCM). States are allowed to cover TCM services without regard to statewideness and comparability requirements. ²² Option to offer supported employment services through HCBS waiver programs to individuals who had been institutionalized some time prior to entering the HCBS waiver program. ²³
1988	Establishment of special financial eligibility rules for institutionalized persons whose spouse remains in the community, to prevent spousal impoverishment. ²⁴
1989	EPSDT mandate amended to require states to cover any service a child needs, even if it is not covered under the State Plan. ²⁵
1993/94	Removal of requirements for physician authorization and nurse supervision for personal care services provided under the State Plan. States explicitly authorized to provide personal care services outside the individual’s home. ²⁶ Personal Care added to the statutory list of Medicaid services. (Personal Care was an option since the mid-1970s, when it was established administratively under the Secretary of Health and Human Services’ authority.)
1997	Removal, under the Balanced Budget Act of 1997, of the “prior institutionalization” test as a requirement for receiving supported employment services through an HCBS waiver program. Addition of first opportunity for states to create a Medicaid “buy-in” for people with disabilities. Establishment of the Program of All Inclusive Care for the Elderly (PACE) as a State Plan option.
1999	Additional options under the Ticket to Work and Work Incentives Act for states to create a buy-in program for people with disabilities and to remove employment barriers. ²⁷
2005	Establishment of a new Medicaid State Plan authority for providing HCBS under §1915(i) of the Social Security Act, under the Deficit Reduction Act of 2005 (DRA-2005), effective 2007. The DRA-2005 also expands options for Medicaid participants to direct their services under HCBS waivers and State Plan Personal Care programs, through §1915(j) of the Social Security Act.
2010	Establishment, under the Affordable Care Act of 2010, of a new authority under §1915(k) of the Social Security Act, effective October 2011. This authority allows states to provide “Community-based Attendant Services and Supports” under the Community First Choice Option.

Mandatory State Plan Services: EPSDT

The Federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children from birth until they turn age 21 entitles Medicaid-eligible children to services found necessary to diagnose, treat, or ameliorate a defect, physical or mental illness, or a condition identified by an EPSDT screen. The original 1967 legislation gave states the option to cover treatment services not covered under the Medicaid State Plan. In 1989, Congress strengthened the EPSDT mandate by requiring states to cover all treatment services defined under §1905(a), regardless of whether or not those services are covered in their Medicaid State Plan.²⁸ As a result, EPSDT programs now cover the broadest possible array of Medicaid services, including personal care and other services provided in the home.

Optional State Plan Services: Personal Care

Since the mid-1970s, states have had the option to offer personal care services under the Medicaid State Plan. This option was first established administratively under the Secretary's authority to add coverages over and above those spelled out in §1905 of the Social Security Act, if such services would further the Social Security Act's purposes. In 1993, Congress took the formal step of adding personal care to the list of services spelled out in the Medicaid statute.²⁹ (See Chapter 4 for more information about the State Plan Personal Care benefit.)

When the Personal Care benefit option was created, it had a decidedly medical orientation. The services had to be prescribed by a physician, supervised by a registered nurse, and delivered in accordance with a service plan. Moreover, they could be provided only in a person's place of residence. Generally, the personal care services a state offered were for assisting individuals to perform activities of daily living (ADLs)—bathing, dressing, eating, toileting, and transferring (e.g., from a bed to a chair). Personal care workers could provide other forms of assistance (e.g., housekeeping and laundry) only on a limited basis and only if they were incidental to the delivery of personal care services.

Starting in the late 1980s, some states sought to broaden the scope of personal care services and provide them outside the individual's home in order to enable beneficiaries to participate in community activities. In 1993, when Congress formally incorporated personal care into Federal Medicaid law, it gave states explicit authorization to provide personal care outside an individual's home.³⁰ Congress went even a step further in 1994, allowing states to (1) use means other than nurse supervision to oversee the provision of personal care services, and (2) establish means other than physician prescription for authorizing such services. In November 1997, CMS issued new regulations concerning optional Medicaid State Plan personal care services to reflect these statutory changes.³¹

In January 1999, CMS released a State Medicaid Manual Transmittal that thoroughly revised and updated guidelines concerning coverage of personal care services. (See the Resources section of this chapter for web links to the Medicaid Manual.) New Manual materials make clear that personal care services may include assistance not only with ADLs but also with instrumental activities of daily living (IADLs), such as personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Additionally, the guidelines clarified that all relatives except "legally responsible relatives" (i.e., spouses, and parents of minor children) could be paid for providing personal care services to beneficiaries.

The Manual further clarified that, for persons with cognitive impairments, personal care may include "cueing along with supervision to ensure the individual performs the task properly." It also explicitly recognized that the provision of personal care services may be directed by the people receiving them. Direction by participants includes training and supervising personal care attendants. The ability of participants to direct their personal care services has been a feature of many personal assistance programs for many years (both under Medicaid and in programs funded only with state dollars). For example, participant direction was built into the Massachusetts Medicaid Personal Care program from its inception. Taken together, these ground-breaking