Medicaid's New Home and Community-Based Services State PlanBenefit

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The HCBS State Plan Option

- Authorized by Section 6086 of the Deficit Reduction Act of 2005 (DRA), Pub. L. No. 101-171 ("Expanded Access to Home and Community-Based Services for the Elderly and Disabled")
- Codified at 42 U.S.C. §1396n(i)
- Frequently referred to as the "1915(i) benefit," as 42 U.S.C. §1396n is §1915 of the Social Security Act

Medicaid's Role in the Delivery of Long-term Supports and Services ("LTSS," or "LTC")

- Medicare coverage for LTC very limited
  - Nursing facility coverage under Medicare *not* "long term"
  - Home health coverage has "homebound" requirement
- Private cost of LTC very expensive
  - $74,000 average annual cost for private nursing facility room (Genworth 2009 Cost of Care Survey)
- Long-term care insurance still not a major "player"
  - Only 6 million individuals currently have coverage
  - Cost a barrier to purchase ("Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance." See www.kff.org)
- Medicaid spends more than $101 billion annually on LTC

The DRA's changes to Medicaid's LTC coverage

- Made drastic changes to Medicaid's transfer-of-asset penalties
  - Increased "look-back" period from three to five years
  - Changed penalty period methodology
- Authorized Money Follows the Person program
  - $1.7 billion authorized for state efforts to transition Medicaid-enrolled institutional residents to the community
  - 31 states received awards
- Expanded authority for Medicaid Long-term Care Partnership Program
  - Provides incentive for purchase of LTC insurance. Medicaid applicants receive asset disregard in eligibility screening equal to amount of private LTC insurance coverage received
  - More than 20 states have adopted Partnership programs

Why "Expand Access" to HCBS?

- Targeting Medicaid's "institutional" bias
- "Balancing," or "Rebalancing" of LTC

Understanding the new HCBS State Plan Option

- Framework of Medicaid and services included in benefits package
- Framework of Medicaid's LTC coverage
- Analysis of HCBS State Plan
  - Eligibility rules
  - Noteworthy design features
  - CMS's Proposed Regulations
- States that have adopted the option
- Congressional proposal to enhance option

Medicaid Eligibility and Services

- Coverage offered to categorical populations
- Mandatory Populations
  - Supplemental Security Income (SSI) recipients (42 U.S.C. §1396a(a)(10)(A)(i))
    - 65 years old or older
    - Under age 65 with a disability
    - Income below SSI federal benefit rate ($674 for single individual) and available assets below $2,000
  - 209(b) eligibles—Individuals 65 years old or older or with disabilities who meet Medicaid income and resource requirements in effect as of January 1, 1972. 42 U.S.C. §1396a(f)

Medicaid Eligibility and Services, continued

- Optional Populations
  - Individuals 65 years old or older or with disabilities not eligible for SSI who meet state Medicaid resource requirements and have income at or below 100% of the federal poverty level (FPL). 42 U.S.C. §1396a(a)(10)(A)(ii)(X)
  - Medically needy individuals (42 U.S.C. §1396a(a)(10)(C))
    - Individuals 65 years old or older or with disabilities who:
      - Meet state Medicaid resource requirements
      - Have income above the state's limit but high medical expenses

Medicaid Services

- Mandatory Services, 42 U.S.C. §1396d(a)(1)-(5), (17) and (21)
  - Inpatient hospital services
  - Outpatient hospital services
  - Laboratory and X-ray services
  - Physician's services
  - Dental surgery services
  - Nursing facility services
  - Home health services

  (partial list)

Medicaid Services, continued

- Optional Services
  - Routine dental services
  - Personal care services
  - Physical therapy services
  - Dentures and prosthetic devices
  - Case management services
  - Respiratory services

  (partial list)

Medicaid Coverage for LTC

- Special income rules apply to individuals who have a clinical need for LTC
- Medicaid "Special Income Category" for nursing facility services (42 U.S.C. §1396a(a)(10)(A)(ii)(V), 42 C.F.R. §435.217)
  - States are authorized to offer automatic Medicaid eligibility to individuals 65 years old or older or with disabilities who have incomes at or below 300% of the SSI FBR ($2,022 for a single individual in 2009) and have a clinical need for nursing facility services
- Individuals who have a clinical need for LTC and have income above the state's special income level may still qualify for Medicaid through either:
  - A state's medically needy category, or
  - Creating an Income Gap (aka "Miller") trust if the state does not offer coverage for nursing facility services to medically needy individuals

Alternative to Nursing Facility Care—HCBS waivers

- States can provide a package of HCBS to individuals who meet state Medicaid NF clinical eligibility standard. HCBS package may include (42 U.S.C. §1396n(c)(4)(B)):
  - Personal care services
  - Homemaker services
  - Case management services
  - Adult day health services
  - Respite services, and
  - *Other services requested by the state as the Secretary may approve*
    - Including, but not limited to
      - Community transition services
      - Environmental modifications
      - Companion services
      - Counseling services
      - Home delivered meals
      - Transportation services

Rules, allowance, and eligibility for State HCBS Waiver programs

- Rules
  - Enrollment limited to individuals "with respect to whom there has been a determination that but for the provision of [HCBS] . . . they would require the level of care provided in a . . . nursing facility."
  - Estimated cost of coverage for HCBS population may not exceed what state would have spent in absence of the waiver
- Allowances
  - States may receive waiver of Medicaid "statewideness" requirement
  - States may receive waiver of Medicaid's "comparability" requirement and may cap number of individuals receiving services
- Eligibility
  - States can adopt Special Income Category for HCBS waiver applicants (i.e., up to 300% of SSI FBR)
  - States may allow Medically Needy to qualify for HCBS waiver services

The HCBS State Plan Option

- "Expanded Access to Home and Community-Based Services for the Elderly and Disabled"

Who is eligible for the HCBS State Plan Benefit?

- The HCBS state plan benefit is an optional service that states can add to their package of Medicaid services.
- Where a state adopts this option, individuals eligible are the "State Plan" beneficiaries
  - SSI recipients
  - In 209(b) states, individuals who meet state's Medicaid income limit
  - Individuals 65 years old or older with incomes at or below 100% of FPL in states that exercise authority in 42 U.S.C. §1396a(a)(10)(A)(ii)(X)
  - Medically Needy? Yes, but . . .
    - Limited to individuals whose income is less than 150% of the FPL

Other features of HCBS State Plan Option

- States may place a cap on the number of individuals receiving coverage for the service
- States may limit coverage for the service to particular areas of the state
- No budget neutrality mandate
- Comparability mandate applies
  - HCBS State Plan option may not be targeted

Questions?

Services available in HCBS waiver programs

- 42 USC 1396N(C)(4)(B):
  - Case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, *and such other services requested by the state as the secretary may approve* and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Services available in HCBS state plan benefit

- 42 USC 1396n(i)(1):
- ". . . a state plan may provide through a state plan amendment for the provision of medical assistance for home and community-based services within the scope of services described in [42 usc 1396n(c)(4)(b)] for which the secretary has the authority to approve a waiver and *not including . . . such other services requested by the state as the secretary may approve* . . ."

Services available in HCBS state plan benefit, continued

- ". . . case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, ~~and such other services requested by the State as the Secretary may approve~~ and for day treatment or other partial hospitalization services psychosocial rehabilitation services, and clinic services . . . for individuals with chronic mental illness."

Services available for individuals with "chronic mental illness"

- Service available in HCBS state plan option: "[D]ay treatment or other partial hospitalization services psychosocial rehabilitation services, and clinic services . . . for individuals with chronic mental illness."
- Iowa's Medicaid HCBS state plan option limited to individuals with chronic mental illness

Multiple 1915(i) plans?

- No. Because Medicaid's comparability requirement applies to the HCBS state plan option, "States may not offer multiple versions of the State Plan HCBS benefit, each designed to serve different groups, as is permitted by HCBS waivers." 73 Fed. Reg. 18684 (proposed April 4, 2008).

HCBS State Plan Clinical Eligibility Standard

- NF/HCBS Waiver standard > HCBS State Plan option standard
- How will states meet this requirement?
  - Example A:
    - State's current NF/HCBS waiver standard = need for assistance with 4 activities of daily living (ADLs)
    - State leaves NF/HCBS waiver standard alone, applies as HCBS state plan option standard a need for assistance with 3 ADLs
  - Example B:
    - State's current NF/HCBS waiver standard = need for assistance with 4 ADLs
    - States *raises* NF/HCBS waiver standard to a need for assistance with 5 ADLs, applies as HCBS state plan option standard a need for assistance with 4 ADLs

Is Method in Example B Permissible?

- 42 U.S.C. §1396n(i)(5): Individuals receiving Medicaid for nursing facility care or enrolled in HCBS waivers as of effective date of HCBS state plan option continue to receive coverage "without regard to whether such individuals satisfy the more stringent eligibility criteria established" by the state.

CMS on narrowing the NF/HCBS Waiver standard

- CMS:
  - "Purpose of the [HCBS state plan benefit] appears to be to expand access to HCBS to individuals who are not at institutional level of care, *rather than to reduce access to institutional and waiver services*." 73 Fed. Reg. 18678 (Emphasis added)
  - Adopting approach of Example A supra is "much simpler strategy." Id.
  - States can avoid "complications" by "preserving existing level of care requirements, and defining the State plan HCBS benefit needs-based criteria as less stringent than the existing institutional criteria." 73 Fed. Reg. 18684

Other issues relating to clinical eligibility standard

- Choice of HCBS state plan benefit v. HCBS waiver?
  - CMS states that individuals meeting both standards have to be offered choice. 73 Fed. Reg. 18679
- Ceiling on HCBS state plan benefit standard?
  - CMS also indicates that states can impose ceiling on standard. 73 Fed. Reg. 18685
    - Example: State's NF/HCBS waiver standard = need for assistance with 4 ADLs. State's HCBS state plan benefit standard = need for assistance with 3 ADLs.
    - State can require individuals with need for assistance with 4 ADLs or more to receive coverage in NF or HCBS waiver

Other issues relating to clinical eligibility standard, continued

- No minimum standard. Receipt of HCBS state plan benefit services a two-step process:
  - Eligibility *assessment*. State *may* "take into account the inability of the individual to perform 2 or more activities of daily living . . ."
  - Individual *evaluation*
    - Occurs *after* Medicaid enrollee has been determined to meet HCBS state plan benefit clinical eligibility standard
    - Evaluation must include "objective evaluation of an individual's inability to perform 2 or more activities of daily living."
    - Evaluation must also be face-to-face, include consultation with treating physician, as well as family members and others "where appropriate," include examination of individual's relevant history, and, as proposed by CMS, a determination of the "community" character of the setting for some individuals.

State authority to change HCBS clinical eligibility standard

- State not required to cap number of Medicaid enrollees who will receive coverage for HCBS state plan benefit, but they must *project* for CMS the number of recipients
- Where state exceeds projection, it may modify HCBS state plan benefit standard to make it harder to qualify
- Individuals receiving HCBS state plan benefit and not eligible under new standard will maintain eligibility "at least 12 months beginning on date the individual first received medical assistance for such services." CMS proposes that no such individual receive continuing coverage for less than 60 days from the point at which the individual is notified of the change. 73 Fed. Reg. 18697

Questions?

Defining "Community" setting

- Money Follows the Person program
  - "Qualified residence" is:
    - A home owned or leased by the individual or individual's family member;
    - An apartment with an individual lease, with lockable access and egress, and which includes areas over which the individual has domain and control; or
    - A residence, in a community setting, in which no more than four unrelated individuals reside.

Defining Community setting, continued

- HCBS state plan benefit
  - CMS proposes that eligibility for HCBS state plan benefit be restricted to individuals residing in home or community:
    - According to standards for community living prescribed by the Secretary
    - If the individual is living in residence with four or more persons unrelated to proprietor, which furnishes one or more treatments or services, independent assessment must include "documentation that the individual is living in a community setting, and not in an institution. 73 Fed. Reg. 18697
- CMS has published "Advanced notice of proposed rulemaking" which features proposal to develop standards for "home and community-based" characteristics. 74 Fed. Reg. 29454 (June 22, 2009).

Approved state plan amendments

- Nevada
  - SPA approved October 2008
  - Services available are adult day health services, habilitation services, and, for individuals with chronic mental illness, day treatment/partial hospitalization
  - Benefit available statewide; no cap on number of individuals receiving coverage
  - Standard: Individual has to meet two of the following factors:
    - Inability to perform two or more ADLs
    - Need for significant assistance to perform two ADLs
    - Risk of harm
    - The need for supervision
    - Functional deficits secondary to cognitive and/or behavioral impairments
  - Nevada did not modify existing nursing facility and HCBS waiver standard in adopting the HCBS state plan benefit

Approved state plan amendments, continued

- Iowa
  - SPA approved April 2007
  - Services available are case management services and habilitation services to individuals who:
    - Have undergone or are currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., partial hospitalization or inpatient hospitalization), or
    - Have a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.
    - Individuals must also have one "risk factor" (e.g., is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history).
  - Iowa will offer the service statewide, but will apply an enrollment limit

Empowered at Home Act of 2009

- S. 434 (Sec. 101: "Removal of Barriers to Providing Home and Community-Based Services under State Plan Amendment Option for Individuals in Need.")
  - Replace 150% FPL income limit with 300%
  - Add "or other such services requested by the State as the Secretary may approve."
  - Eliminate state discretion to cap the number of individuals or limit services to one area of state (i.e., mandate statewideness)
  - Allow HCBS state plan benefit recipients affected by change in standard to being screened under prior standard

Questions?

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