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Medicaid Long-Term Services and Supports: An Overview of Funding Authorities

Medicaid is the primary payer for long-term services and supports (LTSS) for four million Americans – children, adults, and seniors – who experience difficulty living independently and completing daily self-care activities as a result of cognitive disabilities, physical impairments, and/or disabling chronic conditions. Medicaid LTSS are delivered in institutional settings (e.g., nursing facilities) and community-based settings (e.g., private homes). Due in large part to the growth in beneficiary demand for home and community-based services (HCBS) and states' obligations under the U.S. Supreme Court's *Olmstead* decision to provide services to persons with disabilities in community settings rather than institutions, Medicaid HCBS program enrollment and spending have been growing.[1] With the aging of the "Baby Boom" generation into older adulthood and the growing need for LTSS, states and the federal government will continue to be challenged to increase access to HCBS while improving service delivery, managing costs, and maintaining beneficiary protections and autonomy.

States provide Medicaid LTSS under state plan, waiver, and other authorities. Whereas most HCBS are optional for states, nursing facility care is a mandatory Medicaid state plan service, with the result that states' LTSS spending historically has been skewed in favor of institutional care. States have been working to rebalance their LTSS spending and can expand HCBS through waivers and options newly established and expanded by the Affordable Care Act; incentives for states to expand the range of HCBS include enhanced federal funding, flexibility in setting financial eligibility levels and needs based criteria, and population targeting. However, navigating the various Medicaid HCBS options and coordinating new options with existing HCBS programs can present administrative complexities for states. In addition, two of the optional provisions – the Balancing Incentive Program and the Money Follows the Person demonstration – are set to expire in 2015 and 2016, respectively, limiting the amount of time that states have to take advantage of these options. This fact sheet summarizes the various Medicaid LTSS provisions by funding authority (See Table 1).

A companion paper, *Key Issues in State Implementation of the New and Expanded Home and Community-Based Services Options Available Under the Affordable Care Act*, summarizes insights from federal and state officials and experts on state adoption of the ACA HCBS options.[2] For more information on state take-up of the ACA LTSS options, please see *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options*.[3]

Table 1. Overview of Medicaid Long-Term Services and Supports Provisions

Authority	Provision	Description	Mandatory or Optional	FMAP	Self-Direction	Time Limitation
State Plan:	**Institutional Services**					
	Nursing facility services	• Must require daily care provided in facility • Financial eligibility at state option up to 300% Supplemental Security Income (SSI) federal benefit rate (FBR) ($2,130/month for an individual in 2013)	Mandatory	Regular	N/A	No
	Intermediate care facility services for people with intellectual/developmental disabilities	• Must require health or rehabilitative services provided in facility	Optional	Regular	N/A	No
	Home and Community-Based Services (HCBS)					
	Home health services	• Part-time or intermittent nursing services; home health aide services; medical supplies, equipment and appliances suitable for use in the home; and at state option, physical therapy, occupational therapy, and speech pathology and audiology services	Mandatory	Regular	N/A	No
	Personal care services	• Assistance with activities of daily living (e.g., bathing, dressing) and instrumental activities of daily living (e.g., preparing meals)	Optional	Regular	Permitted	No
	Community First Choice state plan option (§ 1915(k))	• Home and community-based attendant services and supports for beneficiaries who would otherwise require institutional care; financial eligibility up to 150% of the federal poverty level (FPL, $1,436/month for an individual in 2013) or up to state limit for nursing facility services if higher	Optional	Enhanced 6%	Required	No

	Health home state plan option	• Services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient & family support, referral to community and social support services
		• To be eligible, individuals must:
		  • have at least two chronic conditions; or
		  • have one chronic condition and be at risk for a second; or
		  • have one serious and persistent mental health condition
		• Geographic targeting permitted
			Optional	Enhanced 90% for specific services for the first 2 years of enrollment per beneficiary	N/A	The state plan option does not expire; only the enhanced FMAP is time-limited

	HCBS state plan option (§ 1915(i))	• Services include: case management, homemaker/home health aide/personal care services, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, chronic mental health clinic services, other services approved by Secretary (same as § 1915(c) HCBS waivers)
		• To be eligible, individuals must:
		  • meet financial eligibility criteria (up to 150% FPL, or $1,436/month for an individual in 2013); states have the option to expand up to 300% SSI FBR ($2,130/month for an individual in 2013) if eligible for HCBS through a waiver
		  • meet needs-based criteria less stringent than institutional care
		• Enrollment caps not permitted
		• Statewideness required
		• Population targeting permitted
			Optional	Regular	Permitted	If a state targets the benefit(s) to specific populations, approval periods are for 5 years, with the option to renew with CMS approval for additional 5-year periods

Waivers:	**Section 1915(c)**	• Services include: case management, homemaker/home health aide/personal care services, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, chronic mental health clinic services, other services approved by Secretary (same as the § 1915(i) state plan option) • Beneficiaries must otherwise require institutional care • Secretary can waive regular program income and resource limits • Cost neutrality required • Enrollment caps permitted • Statewideness not required • Population targeting permitted	Optional	Regular	Permitted	Section 1915(c) waivers are approved initially for a 3-year period and renewed for 5-year periods
	Section 1115	• Secretary can waive certain Medicaid requirements and allow states to use Medicaid funds in ways that are not otherwise allowable under federal rules for experimental, pilot, or demonstration projects that in the Secretary's view are likely to assist in promoting program objectives • Budget neutrality required through longstanding administrative policy	Optional	Regular	Permitted	In general, Section 1115 demonstrations are approved for a 5-year period and can be renewed, typically for an additional 3 years
Other HCBS Programs:	**Money Follows the Person**	• HCBS for beneficiaries who transition from an institution to a community-based setting • Includes supplemental services not otherwise matchable to facilitate transition	Optional	Enhanced	Permitted	Demonstration grant through September 2016
	Balancing Incentive Program	• New or expanded HCBS for beneficiaries with incomes up to 300% SSI FBR ($2,130/month for an individual in 2013) • Must develop no wrong door/single entry point system, conflict-free case management services, and core standardized assessment • States must spend at least 50% of total LTSS expenditures on non-institutionally based LTSS by September 30, 2015	Optional	Enhanced 2% or 5% for states that spent less than half of total Medicaid long-term care expenditures on HCBS as of 2009	Permitted	State plan option or waiver from October 2011 through September 2015

ENDNOTES

[1] For state-level participant and expenditure data, *see* Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: 2009 Data Update* (December 2012), available at http://www.kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/.

[2] Available at http://kff.org/medicaid/issue-brief/key-issues-in-state-implementation-of-the-new-and-expanded-home-and-community-based-services-options-available-under-the-affordable-care-act.

[3] Available at http://www.kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/; updates are available on the Kaiser Family Foundation's *State Health Facts* website, available at: http://www.kff.org/state-category/health-reform/.