Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies

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REPORT

Medicaid HCBS Enrollment in 2014

Home Health, Personal Care, and Section 1915 (c) Waiver Enrollment

Nearly 3.2 million people received services through the three main Medicaid HCBS programs in 2014 (Table 1A). They include 867,996 people who received home health services through the mandatory state plan benefit offered by all 50 states and DC (Table 1B); 724,788 people who received personal care services through the optional state plan benefit offered by 33 states and DC (Table 1C);[1] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-1) and 1,575,227 people who received HCBS through optional Section 1915 (c) waivers offered by 47 states and DC (Table 1D). The three states tha did not offer any Section 1915 (c) waivers in 2014 (Arizona, Rhode Island, and Vermont) instead provided HCBS through Section 1115 capitated MLTSS waivers, which are discussed later in this report.

Section 1915 (c) waivers continue to comprise about half of total Medicaid HCBS enrollment across the three main programs. People receiving home health state plan services make up just over a quarter of total HCBS enrollment, and those receiving personal care state plan services account for just under a quarter of total enrollment across the three main HCBS programs (Figure 1).

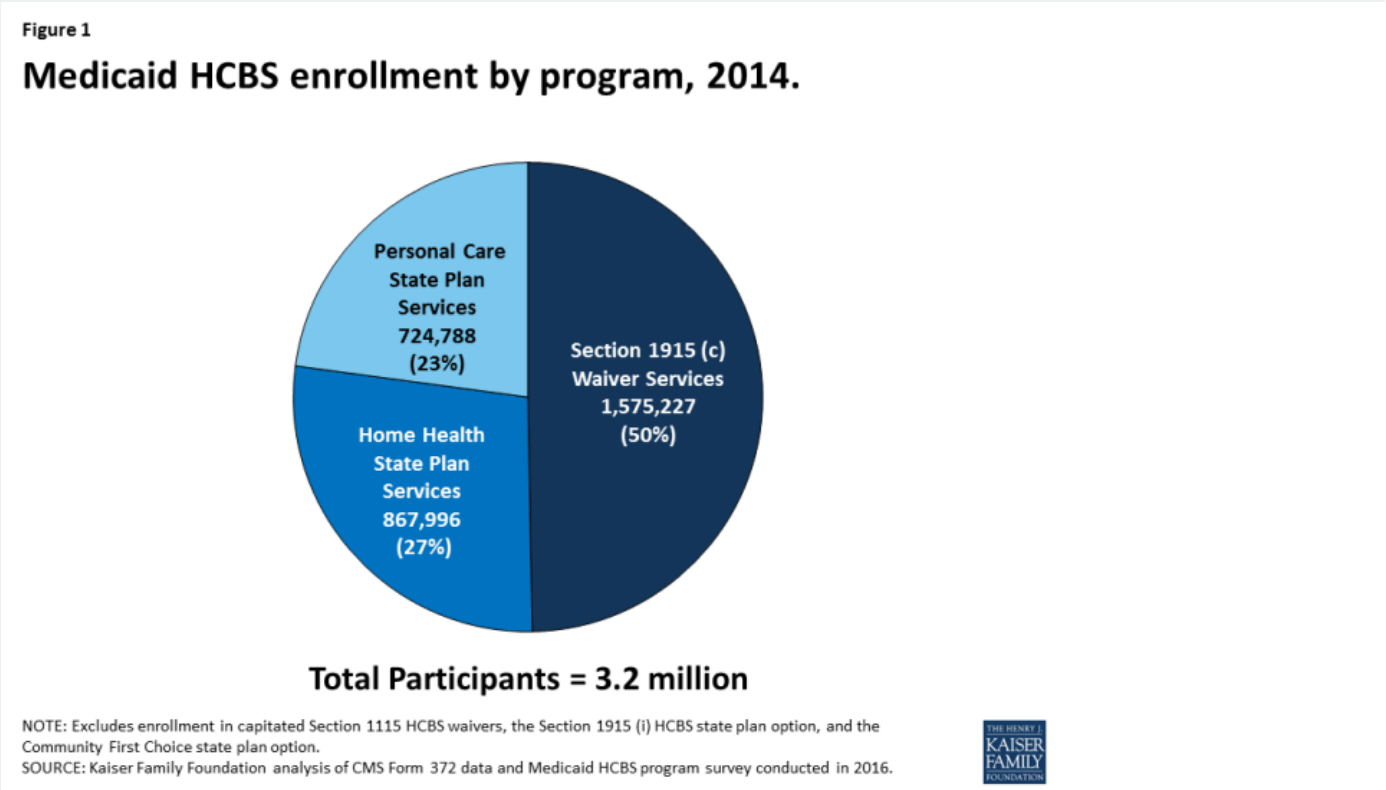


Figure 1: Medicaid HCBS enrollment by program, 2014.

SECTION 1915 (C) WAIVER ENROLLMENT BY TARGET POPULATION

Forty-seven states and DC offered a total of 287 Section 1915 (c) HCBS waivers targeted to different populations in 2014 (Table 4).[2] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-2) These waivers allow states to expand financial eligibility and offer HCBS to seniors and people with disabilities who would otherwise qualify for an institutional level of care. Our survey categorizes Section 1915 (c) waivers as serving the following populations: people with intellectual or developmental disabilities (I/DD), seniors, both seniors and nonelderly adults with physical disabilities, nonelderly adults with physical disabilities, children who are medically fragile or technology dependent, people with HIV/AIDS children and adults with mental health disabilities,[3] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-3) and people with traumatic brain or spinal cord injuries (TBI/SCI).

The number of Section 1915 (c) waivers offered by states ranged from one to 11, depending on the number of populations targeted (Table 4). Some states, such as Delaware, Hawaii, and New Jersey, operated only one Section 1915 (c) waiver; these states, along with California, New Mexico, New York, Tennessee, and Texas used Section 1915 (c) waivers to provide HCBS for some populations and Section 1115 capitated MLTSS waivers (discussed later) for other populations.[4] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-

policies/view/footnotes/#footnote-247231-4) By contrast, Colorado operated 11 Section 1915 (c) waivers, and five other states (Connecticut, Massachusetts, Missouri, New York, and Pennsylvania) operated 10 Section 1915 (c) waivers targeted to different populations.

Over half (54%, or 842,773 individuals) of Section 1915 (c) enrollment was in waivers targeted to seniors and/or nonelderly adults with physical disabilities (Table 4 and Figure 2). The next largest group of Section 1915 (c) waiver enrollees (42%, or 655,429 individuals) were people with I/DD. The Section 1915 (c) waiver populations with the smallest enrollment were children who are medically fragile or technology dependent (34,647 individuals), people with mental health disabilities (19,199 individuals), people with HIV/AIDS (12,065 individuals), and people with TBI/SCI (11,114 individuals) (Tables 4 and 5).

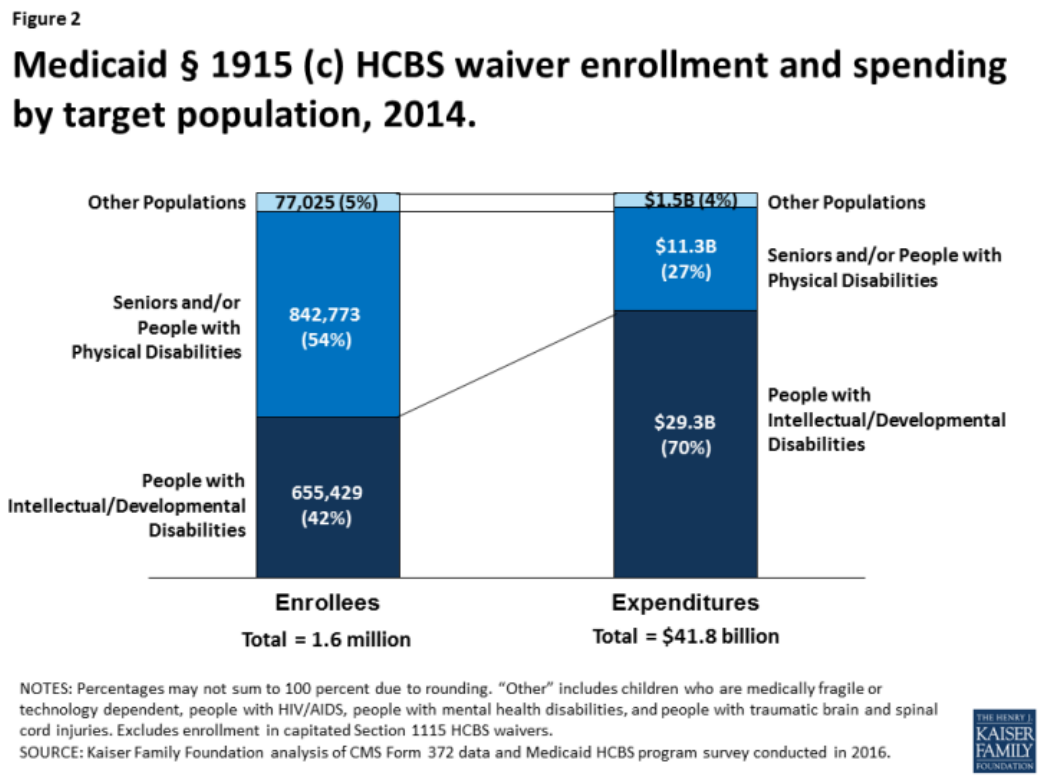


Figure 2: Medicaid § 1915 (c) HCBS waiver enrollment and spending by target population, 2014.

SECTION 1915 (C) WAIVER ENROLLMENT BY SERVICE TYPE

States provide a range of different HCBS through Section 1915 (c) waivers, which our survey groups into nine categories: (1) case management, (2) home-based services (including personal care, companion services, home health, respite, chore/homemaker services, and home-delivered meals), (3) day services (including day habilitation and adult day health services), (4) nursing/other health/therapeutic services, (5) round-the-clock services (including in-home residential habilitation, supported living, and group living), (6) supported employment/training, (7) other mental health and behavioral services (including mental health assessment, crisis intervention, counseling, peer specialist), (8)

equipment/technology/modifications (such as personal emergency response systems, home and/or vehicle accessibility adaptions), and (9) other services (including non-medical transportation, community transition services, payments to managed care, and goods and services). The service categories in this year's survey have been revised and expanded to reflect CMS's HCBS Taxonomy.[5] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-5)

In 2014, the vast majority (70%, or 1.1 million individuals) of Section 1915 (c) waiver enrollees received home-based services (Table 6). The most common type of home-based service provided to waiver enrollees was personal care (received by 42%, or 456,562 individuals), followed by respite (17%, or 191,208 individuals), and chore/homemaker (16%, or 173,172 individuals) (no table shown). Ohio and Pennsylvania provided personal care services to the largest number of Section 1915 (c) waiver enrollees, serving 75,230 and 34,107 individuals respectively. These states do not offer the optional state plan personal care services benefit. The next largest group of Section 1915 (c) waiver service enrollment was day services (45%, or 707,173 individuals). Over 588,000 people (37%) received case management services through a Section 1915 (c) waiver. Total Section 1915 (c) waiver enrollees by service type exceeds the unduplicated number of total waiver enrollees because waiver enrollees ma receive more than one waiver service.

HCBS Enrollment Trends

Enrollment in the three main Medicaid HCBS programs increased by five percent between 2013 and 2014. This increase followed a six percent decline in HCBS enrollment from 2012 to 2013, and exceeded the 10-year average HCBS enrollment growth rate of two percent from 2004-2014 (Table 1A and Figure 3). Most states (32 states and DC) had increases in HCBS enrollment across the three main programs between 2013 and 2014, led by South Dakota and DC. Specifically, South Dakota had a large increase in home health state plan enrollment. DC's growth is attributable to a sizeable increase in personal care state plan service enrollment, which led to an FBI audit and implementation of a process aimed at improving the accuracy of needs assessment determinations, according to District officials. A minority of states (14) reported a decline in enrollment across the three main HCBS programs from 2013 to 2014; however, the two states with the largest declines (Delaware and New Mexico) do not represent a net loss in overall Medicaid HCBS enrollment, as both of these states transitioned enrollees from one or more of the three main HCBS authorities to a Section 1115 capitated MLTSS waiver in 2014.

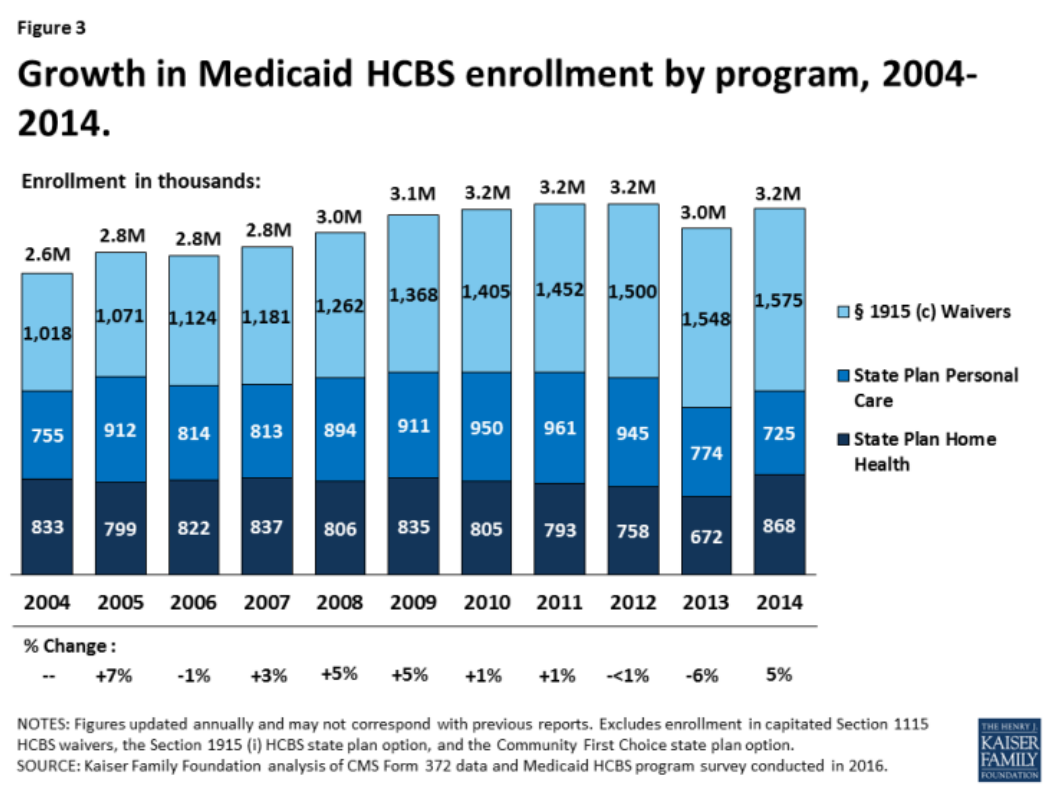


Figure 3: Growth in Medicaid HCBS enrollment by program, 2004-2014.

Most of the increase in overall HCBS enrollment from 2013 to 2014 is due to a 27 percen increase in home health state plan service enrollees. This increase followed a 10 percent decline in home health state plan services enrollment during the previous year and marks the first percent increase in home health enrollment since 2009 (Table 1B). The three states reporting the largest increases in home health state plan enrollment in 2014 were South Dakota, Minnesota, and Pennsylvania.

Enrollment in personal care state plan services declined by 6 percent from 2013 to 2014 following an 18 percent decrease from 2012 to 2013 (Table 1C). Some of this decline may be attributable to states offering HCBS through other authorities, such as Community First Choice, Section 1915 (i), and/or Section 1115 waivers. For example, California offers both CFC and Section 1915 (i) HCBS and reported a twenty percent decline in personal care state plan services, resulting in nearly 60,000 fewer participants between 2013-2014. Twenty states reported increases and eleven states reported decreases in personal care state plan services between 2013 and 2014. Oregon attributes its large increase in personal care state plan enrollment from 2013 to 2014 to a reporting change.

Enrollment growth in Section 1915 (c) waivers from 2013 to 2014 also was small (2%), and slightly lower than the three percent increase from 2012 to 2013 (Table 1D). Thirty-one states reported increases in Section 1915 (c) waiver enrollment, and 17 states reported decreases from 2013 to 2014. Two states reporting large decreases in Section 1915 (c) waiver enrollment (New Jersey and New Mexico) do not represent a net loss in overall Medicaid HCBS enrollment as both of those states moved enrollees from Section 1915 (c) to Section 1115

capitated MLTSS waivers in 2014. With the exception of those two states and Utah's 73% increase, most states did not experience large percent changes in Section 1915 (c) waiver enrollment between 2013 and 2014.

When looking at Section 1915 (c) waivers by target population, those that focused on both seniors and people with physical disabilities (9%) and only people with physical disabilities (8%) had the largest increases in enrollment from 2013 to 2014 (Table 5). Enrollment in Section 1915 (c) waivers targeting people with I/DD rose by five percent from 2013 to 2014. Total waiver enrollment for other target populations decreased from 2013 to 2014, including a 35 percent drop in TBI/SCI waiver enrollment, a 24 percent drop in senior waiver enrollment, and a two percent drop in HIV/AIDS waiver enrollment. However, this doe not represent a net decrease in people receiving HCBS waiver services, as Delaware, New Jersey, and New Mexico terminated Section 1915 (c) waivers for these populations in 2014, and instead cover these populations through Section 1115 capitated MLTSS waivers. Other Section 1915 (c) waiver enrollment changes between 2013 and 2014 are attributable to changes in survey reporting: beginning in 2014, we include waivers serving children with serious emotional disturbance or serious mental illness in the "mental health disabilities" group as distinct from waivers serving children who are medically fragile or technology dependent.

HCBS Enrollment Changes and State Adoption of ACA Medicaid Expansion

The overall increase in enrollment across the three main HCBS programs from 2013 to 2014 is notable as many states also experienced enrollment increases from implementing the ACA's Medicaid expansion in 2014. The ACA authorizes states to expanc Medicaid eligibility to nearly all adults with income up to 138% of the federal poverty level (FPL, $16,643/year for an individual in 2017).[6] (https://www.kff.org/medicaid/report/medicaid-home-anc community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-6) The two populations are not mutually exclusive as Medicaid expansion enrollees can receive home health or personal care state plan services, if those services are medically necessary and included in the state's expansion adult benefit package. After South Dakota (a non-expansion state) and DC (extenuating circumstances discussed above), some of the states with larger increases in HCBS enrollment from 2013 to 2014, such as Iowa (59%), Minnesota (34%), and Rhode Island (33%), also implemented the ACA Medicaid expansion in 2014. Besides Delaware and New Mexico (both of which moved enrollees from traditional HCBS authorities to Section 1115 waivers, as discussed above), states with HCBS enrollment decreases from 2013 to 2014 included both expansion states an non-expansion states, with some of the greater decreases in HCBS enrollment in non-expansion states, such as Georgia (-18%) and Mississippi (-18%). New Hampshire, which implemented the Medicaid expansion in August 2014, reported a 22 percent decrease in HCB enrollment from 2013 to 2014. (Table 1A).

State-level data do not support a correlation between increased or decreased enrollment in the optional personal care services state plan benefit and a state's ACA expansion status. Some of the states with larger decreases in personal care state plan

services enrollment from 2013 to 2014 were non-expansion states, such as Florida (-84%), Utah (-29%), and Oklahoma (-21%). Conversely, some of the states with larger increases in personal care state plan services enrollment from 2013 to 2014 were expansion states, such as Minnesota (49%), Arkansas (25%), New Jersey (21%), and Massachusetts (20%).

Medicaid HCBS Spending in 2014

Home Health, Personal Care, and Section 1915 (c) Waiver Spending

Total Medicaid spending on HCBS across the three main programs was $58.5 billion in 2014 (Table 2A). As in past years, the large majority (72%) of Medicaid HCBS spending was for Section 1915 (c) waivers, totaling $41.8 billion in 2014 (Table 2D). Medicaid spent $10.1 billion on personal care state plan services and $6.6 billion on home health state plan services (Tables 2B and 2C and Figure 4).

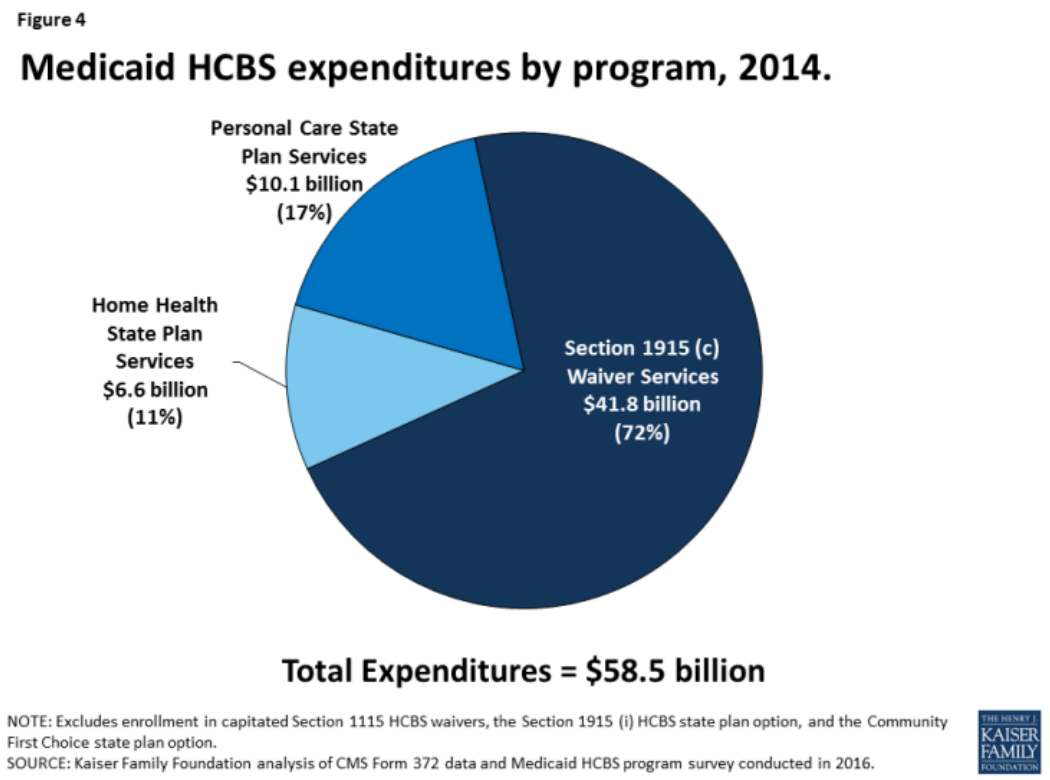


Figure 4: Medicaid HCBS expenditures by program, 2014.

SECTION 1915 (C) WAIVER SPENDING BY TARGET POPULATION

Spending on Section 1915 (c) waivers targeted to people with I/DD accounted for 70 percent of all Section 1915 (c) waiver spending (Tables 5 and 7 and Figure 2). Although individuals with I/DD accounted for 42 percent of total Section 1915 (c) waiver enrollees, spending for this population was disproportionate to their enrollment as a result of their generally more intensive needs. Spending on Section 1915 (c) waivers targeted to seniors and/or people with physical disabilities accounted for slightly more than half (54%) of total Section 1915 (c) waiver enrollment but just over a quarter (27%) of spending (Figure 2).

SECTION 1915 (C) WAIVER SPENDING BY SERVICE TYPE

Thirty-seven percent of total Section 1915 (c) waiver spending went to round-the-clock services. Residential habilitation services for individuals with I/DD in New York accounted for 21 percent ($3.2 billion) of the $15.5 billion total spending on round-the-clock waiver services. The next two largest waiver spending service categories were home-based services (25% or $10.6 billion) and day services (20% or $8.3 billion) (Table 8). Spending on other services, including non-medical transportation, community transition services, payments to managed care, and goods and services, accounted for 9 percent of waiver spending (or $3.9 billion). Case management services and equipment/technology/modifications comprised smaller shares of total waiver spending; even though these services were relatively widely used, they are not as expensive to provide as some other types of waiver services.

HCBS Spending Trends

Spending in the three main Medicaid HCBS programs increased by three percent from 2013 to 2014 (Figure 5). Over the 10-year period from 2004 to 2014, total annual spending in the three main HCBS programs increased by six percent on average with the lowest annual spending growth (about 1%) between 2011 and 2012, followed by a three percent increase from 2012 to 2013. Although spending growth was slow from 2013 to 2014, 34 states reported increased HCBS spending, while 14 states reported decreases during this period (Table 2A). New Mexico's 52 percent spending decrease is not a net loss in overall HCBS spending but rather can be attributed to its change of HCBS authority to a Section 1115 capitated managed care waiver in 2014.

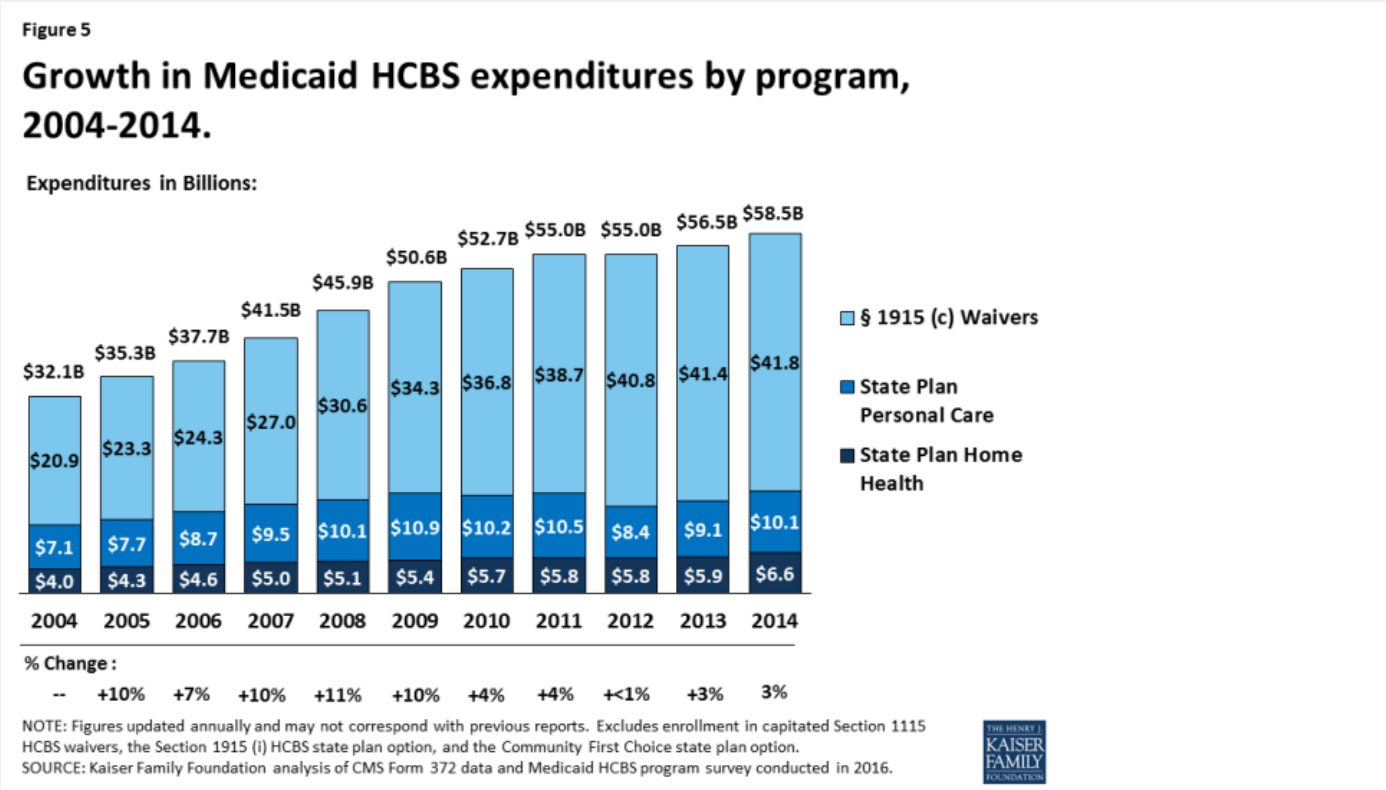


Figure 5: Growth in Medicaid HCBS expenditures by program, 2004-2014.

Consistent with changes in HCBS enrollment, most spending growth from 2013 to 2014 was for home health state plan services (Table 2B). The eleven percent increase in spending on home health state plan services from 2013 to 2014 followed a two percent decrease from 2012 to 2013. Driven by a thirty percent increase in California, overall spending on personal care state plan services increased by ten percent from 2013 to 2014, after a nine percent increase the prior year (Table 2C). The one percent increase in Section 1915 (c) waive spending from 2013 to 2014 was the same as the prior year's increase (Table 2D).

When looking at Section 1915 (c) waivers by target population, the waivers with the largest annual rate of spending growth between 2013 and 2014 targeted both seniors and people with physical disabilities (19%) and people with physical disabilities (13%), consistent with enrollment growth during this period (Table 5). Spending on Section 191 (c) waivers targeted to people with I/DD remained relatively flat (less than 1% increase) from 2013 to 2014. There was a sharp fall (-33%) in spending on waivers serving people with TBI/SCI and a 15 percent decline in waivers serving people with HIV/AIDS. However, both of these decreases can be largely attributed to New Jersey moving its TBI and HIV/AIDS HCBS populations from Section 1915 (c) to Section 1115 waiver authority rather than a net loss in overall HCBS enrollment. Similarly, changes in spending for Section 1915 (c) waivers serving seniors can be largely attributed to changes from Section 1915 (c) to Section 1115 waiver authority, in states such as Delaware, New Jersey and New Mexico. Finally, changes in spending for Section 1915 (c) waivers serving children and individuals with mental illness were primarily due to reporting changes.

HCBS Spending Per Enrollee

Medicaid HCBS spending per enrollee averaged $18,458 nationally in 2014, with substantial state-level variation (Table 3A and Figure 6). For example, five states (Oregon, Rhode Island, South Dakota, Texas, and Vermont) spent less than $10,000 per enrollee, while seven states (Alaska, Delaware, Maine, New Hampshire, New Mexico, New York, and Tennessee) spent more than $30,000 per enrollee. Higher per enrollee spending in Delaware, New Mexico, and Tennessee is likely at least in part due to the transfer of most HCBS waiver populations from Section 1915 (c) to Section 1115 authority in those states, leaving all or most of their remaining Section 1915 (c) waivers targeted to people with I/DD, who may have more intensive needs and therefore higher spending compared to other target populations.

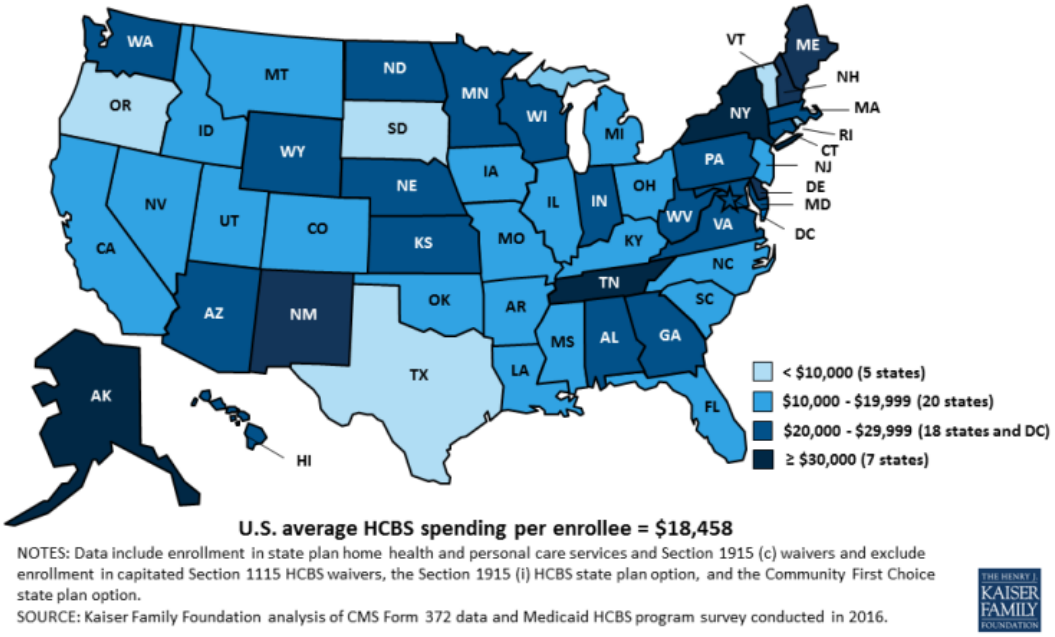


Figure 6: State variation in Medicaid HCBS program expenditures per person served, 2014.

National per enrollee spending also varied across the three major HCBS programs, ranging from $7,570 for home health services to $26,563 for Section 1915 (c) waivers (Tables 3B, 3C, 3D, and Figure 7). This difference is likely due to the type and extent of service provided in the different HCBS programs. Lower national per enrollee spending on home health state plan services relative to the other two programs likely reflects shorter periods of per enrollee service utilization compared to personal care state plan or Section 1915 (c) waive services.

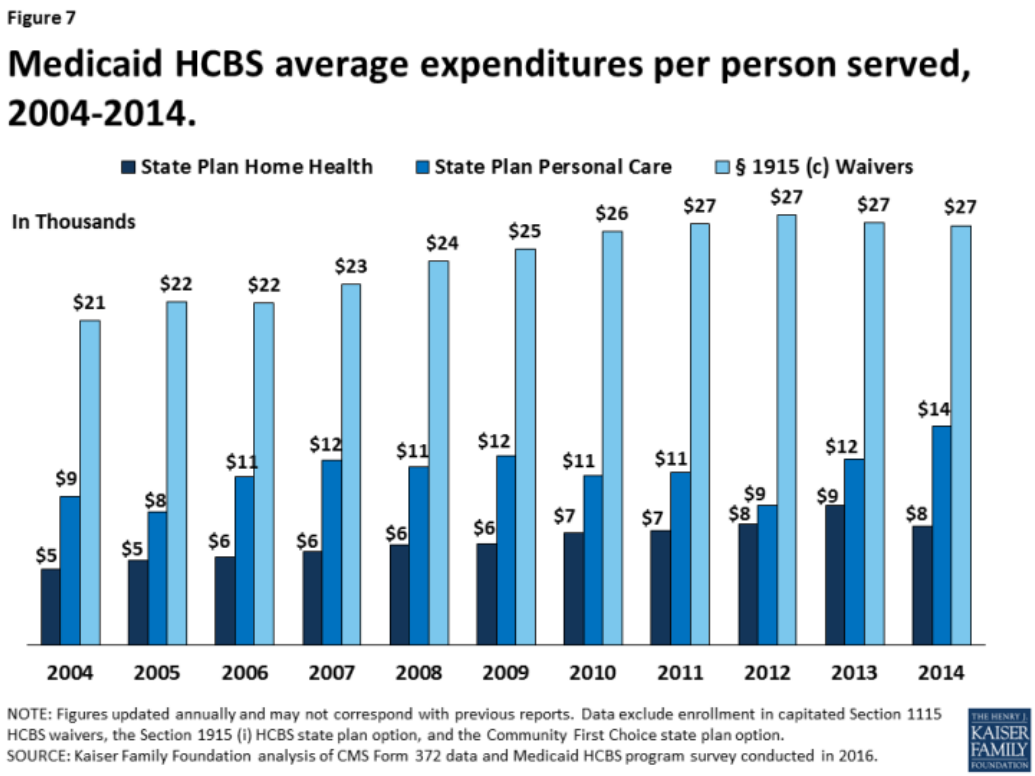


Figure 7: Medicaid HCBS average expenditures per person served, 2004-2014.

While total Medicaid HCBS spending across the three main programs increased slightly (by 3%) from 2013 to 2014, as noted above, HCBS spending per enrollee across the three main programs declined by two percent over this period (Table 3A). Home health spending per enrollee declined by fourteen percent, and personal care state plan services spending per enrollee increased by eighteen percent. Section 1915 (c) waiver spending per enrollee decreased by less than one percentage point (-0.8%) from 2013 to 2014, following a two percent decline the previous year. The 10-year average growth in Section 1915 (c) waiver per enrollee spending from 2004 through 2014 was three percent (Table 3D).

SECTION 1915 (C) WAIVER PER ENROLLEE SPENDING BY TARGET POPULATION

There was substantial variation in per enrollee spending among Section 1915 (c) waiver targeted to different populations, with those targeted to people with I/DD having the highest per enrollee spending ($44,629) (Tables 5 and 9). Although Section 1915 (c) waiver spending per enrollee for people with I/DD was more than four times higher than per enrollee spending for waivers targeted to seniors ($10,189) and more than three times higher than per enrollee spending for waivers targeted to both seniors and people with physical disabilities ($12,837), I/DD waiver spending per enrollee fell by four percent from 2013 to 2014. Per enrollee spending grew by 10 percent from 2013 to 2014 for waivers targeted to both seniors and people with physical disabilities, while per enrollee spending declined in waivers targeted to people with HIV/AIDS (-13%) and seniors (-14%) (Table 5). The declines in per enrollee

spending from 2013-2014 do not all represent a net loss in spending on Medicaid waiver HCBS, due to states moving from Section 1915 (c) to Section 1115 and to reporting changes fo waivers affecting children and people with mental health needs, as described above.

SECTION 1915 (C) WAIVER PER ENROLLEE SPENDING BY SERVICE TYPE

The category of waiver services with the highest spending per enrollee was round-the-clock services ($44,811), reflecting the intensity of these services compared to other types (Table 10). However, there is large inter-state variation in round-the-clock service spending per enrollee, ranging from $5,416 in Louisiana to $100,961 in Connecticut. The next highest waiver service category was day services, at $11,717 per enrollee. Again, there is large inter-state variation in day service spending per enrollee, ranging from $482 in Indiana to $41,029 in West Virginia. Case management and equipment/technology/ modifications were the least expensive Section 1915 (c) waiver services nationwide at $1,756 and $670 per enrollee (Table 10).

Medicaid HCBS Provided Through Capitated Managed Care: Program Policies in 2016

This year's survey asked the 24 states with capitated MLTSS programs in 2016 to report on selected policies to gauge state progress with implementing key provisions of the revised Medicaid managed care regulations, including independent enrollment choice counseling, disenrollment for cause if an LTSS provider leaves the plan network, network adequacy standards, and stakeholder advisory committees. The 2016 revision of these regulations, issued under the Obama Administration, for the first time addressed capitated MLTSS programs; different provisions of the regulations have different effective dates.[7] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-7) Under the Trump Administration, CMS issued a June 2017 informational bulletin indicating that it "intends to us [its] enforcement discretion. . . when states are unable to implement new and potentially burdensome requirements of the final [managed care] rule by the required compliance date, particularly provisions with a compliance deadline of contracts beginning on or after July 1, 2017," while CMS reviews the managed care regulations and considers changes through futur rule-making.[8] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-8)

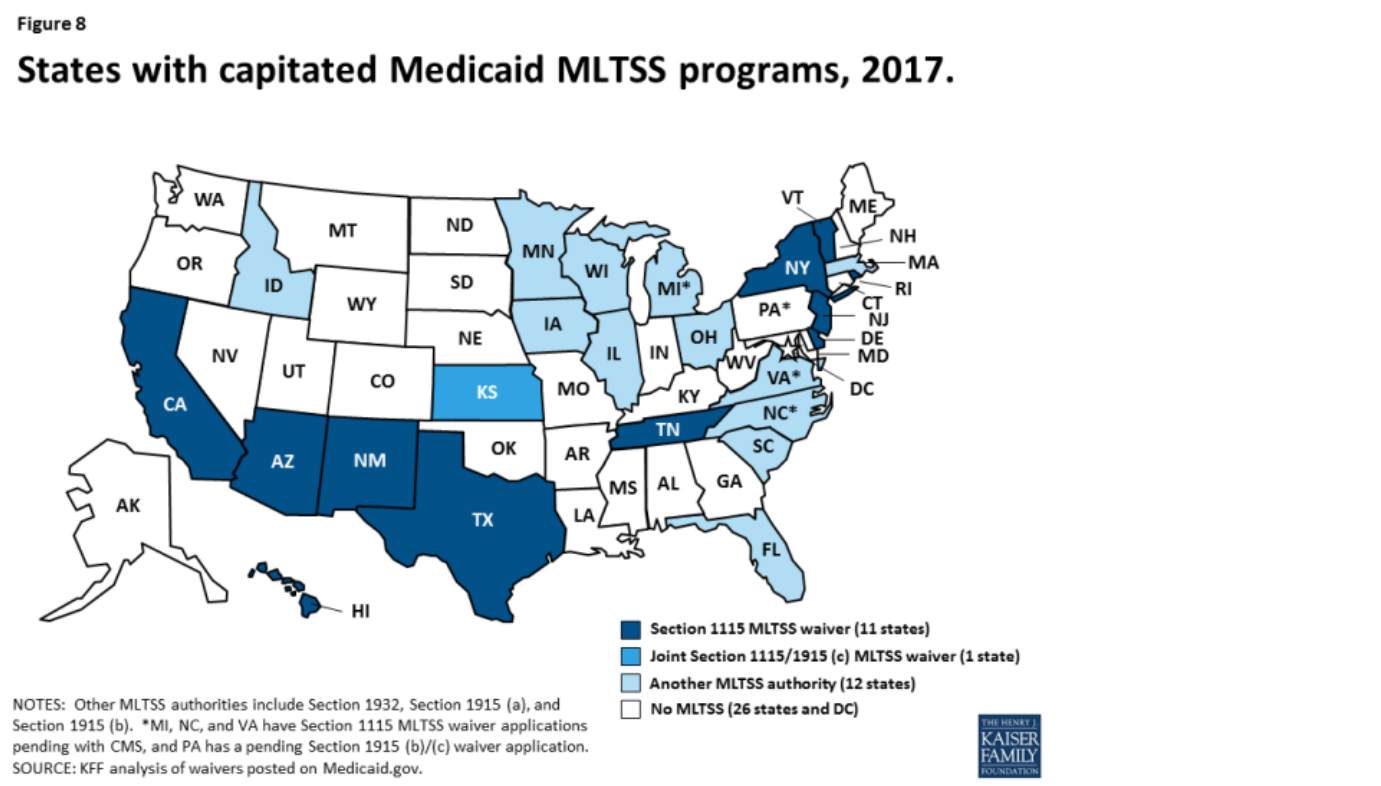


Figure 8: States with capitated Medicaid MLTSS programs, 2017.

INDEPENDENT ENROLLMENT OPTIONS COUNSELING

Seventeen states (71% of the 24 MLTSS states) provided MLTSS enrollees with independent enrollment options counseling in 2016. Some states contract with a third party enrollment broker, while others rely on community-based organizations such as aging and disability resource centers or ombudsman programs. By contrast, Arizona uses state eligibility caseworkers to provide enrollment counseling. Options counseling seeks to help MLTSS enrollees select a health plan; this population may not be familiar with that process because they traditionally have been enrolled in the fee-for-service delivery system. MLTSS enrollees also may seek assistance with choosing a health plan to find a provider network tha best meets their various needs – which may go beyond primary care to include specialists, behavioral health providers, durable medical equipment suppliers, and personal care attendants — and preserves their existing provider relationships to the extent possible. CMS's 2016 Medicaid managed care regulations require all states to offer enrollee choice counseling through the independent beneficiary support system required in health plan contracts beginning on or after July 1, 2018.[9] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-9)

DISENROLLMENT IF LTSS PROVIDER LEAVES PLAN NETWORK

Thirteen states (54% of the 24 MLTSS states) allow MLTSS beneficiaries to disenroll from their health plan if their residence or employment would be disrupted due to an LTSS provider leaving the plan network in 2016. Under the 2016 Medicaid managed care regulations, states must consider these circumstances as good cause for disenrollment for health plan contracts beginning or after July 1, 2017.[10] (https://www.kff.org/medicaid/report/medicaid home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-10)

LTSS NETWORK ADEQUACY STANDARDS

Thirteen states (54% of the 24 MLTSS states) require network adequacy standards for LTSS providers in 2016. For example, Tennessee includes specific service initiation timeframes, while Arizona requires reporting of service gap incidents. Minnesota requires its MLTSS health plans to include the entire fee-for-service provider network. The 2016 managed care regulations require states to develop time and distance standards for MLTSS providers when the enrollee must travel to the provider, and network adequacy standards other than time and distance standards for MLTSS providers that travel to the enrollee to deliver services These standards are required for health plan contracts beginning on or after July 1, 2018.[11] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-11)

STAKEHOLDER ADVISORY COMMITTEES

Twenty states (83% of the 24 MLTSS states) had a state-level managed care advisory committee, and 19 states (79%) required health plans to have a stakeholder advisory committee in 2016. For example, Illinois' state Medicaid advisory committee includes an LTS subcommittee that provides advice on planning and policy. Ohio requires its MLTSS health plans to hold quarterly member advisory council meetings. The 2016 Medicaid managed care regulations require states to create and maintain a stakeholder group to solicit and address the opinions of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders in the design, implementation, and oversight of a state's MLTSS program. In addition, plans providing MLTSS must have a member advisory committee that includes at least a reasonably representative sample of the populations receiving LTSS covered by the plan or other individuals representing those enrollees. These provisions are effective for health plan contracts beginning on or after July 1, 2017.[12] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-12)

Medicaid HCBS Program Policies in 2016

Section 1915 (c) and Section 1115 HCBS Waiver Policies

Under Medicaid HCBS waiver authority, states can use a range of cost containment strategies to meet federal cost neutrality requirements and control state spending. States also can appl policies that affect the type of services received and the number of people served by these waivers. These policies include waiting lists; financial and functional eligibility criteria; cost

controls; self-direction, including changes in response to the U.S. Department of Labor direct care worker minimum wage and overtime rule; quality measures; waiver consolidation; and changes in response to the home and community-based settings rule. We surveyed all state Section 1915 (c) and Section 1115 HCBS waiver administrators in 2016 to report on these key policy areas.

WAITING LISTS

Three-quarters of states (39 out of 51) reported Section 1915 (c) or Section 1115 HCBS waiver waiting lists in 2016, up from 36 states in 2015 (Tables 11 and 12). Unlike Medicaid state plan services, states can cap enrollment for HCBS provided through waivers. The maintenance and length of waiver waiting lists has implications for states' compliance with their community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. National waiver waiting list enrollment increased to 656,195 individuals across 116 Section 1915 (c) and two Section 1115 HCBS waivers in 2016, u from 640,841 individuals across 133 Section 1915 (c) waivers in 2015. The 2016 total includes individuals on Section 1115 HCBS waiver waiting lists reported by Section 1115 waivers in Nev Mexico and Texas;[13] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-13) prior years include only Section 1915 (c) waiver waiting lists. Individuals waiting for HCBS waivers targeted to those with I/DD comprised 65 percent of total waiting list enrollment (423,735 individuals), followed by those waiting for waivers targeted to seniors and/or and adults with physical disabilities (28% of waiting list enrollment, or 182,429 individuals) (Table 12 and Figure 9).

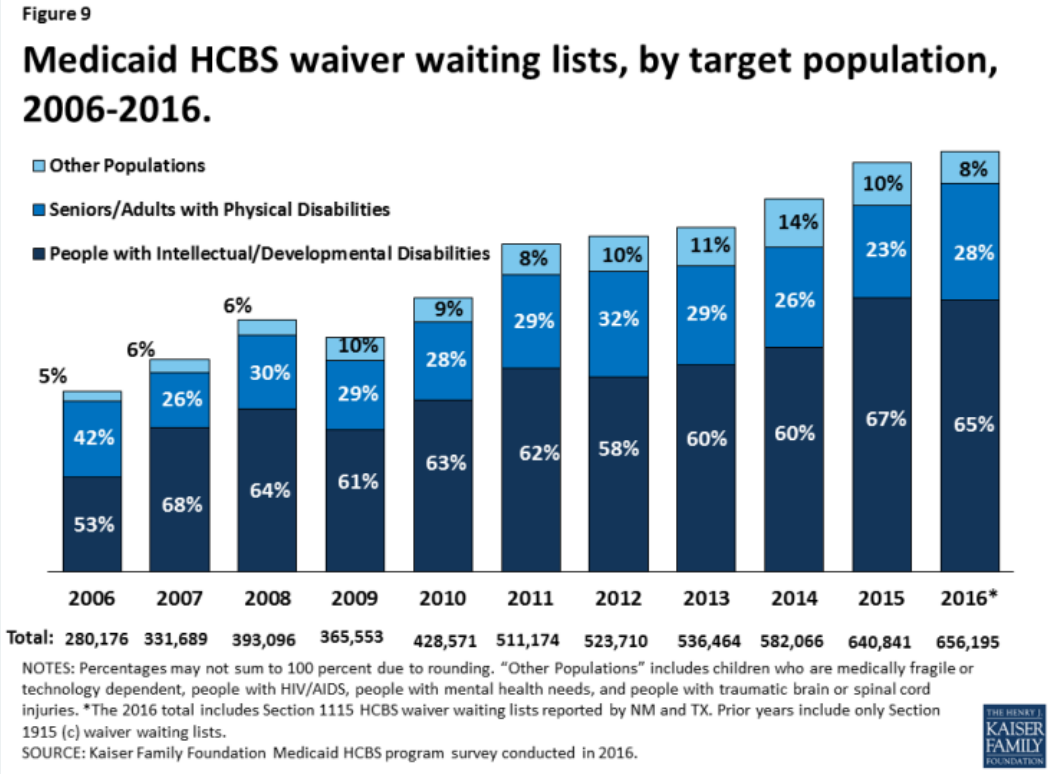


Figure 9: Medicaid HCBS waiver waiting lists, by target population, 2006-2016.

Waiting time for waiver services averaged 23 months across all HCBS waivers with waiting lists in 2016. Average waiting list time varied substantially by waiver target population, ranging from five months for HIV/AIDS waivers to 48 months for waivers targeted to people with I/DD. Nearly 60 percent (23 of 39) of states moved a total of 72,380 individuals off a waiting list (by offering them waiver services) in the past year; the other states with waiver waiting lists either did not have this data available or did not respond to this survey question. States with waiver waiting lists reported that virtually all (93%) of individuals on waiting lists currently live in the community (25 states reporting; 14 states did not respond).

Nearly ninety percent of waivers with waiting lists provided non-waiver services (i.e., Medicaid state plan services, such as personal care) to individuals enrolled in Medicaid who were waiting for waiver services. In addition, over half (53%) of waivers with waiting lists screened individuals for waiver eligibility before being place or while on a waiting list (Table 11). Nearly three-quarters (70%) of waivers with waiting lists had policies to prioritize certain individuals to receive waiver services when slots become available. For example, 33 waivers prioritized people who are moving from an institution to the community, and 13 waivers prioritized people who are at risk of entering an institution without waiver services. A minority of states also reported giving priority to individuals who meet specific crisis or emergency criteria (10 states) and/or based on assessed level of need (6 states).

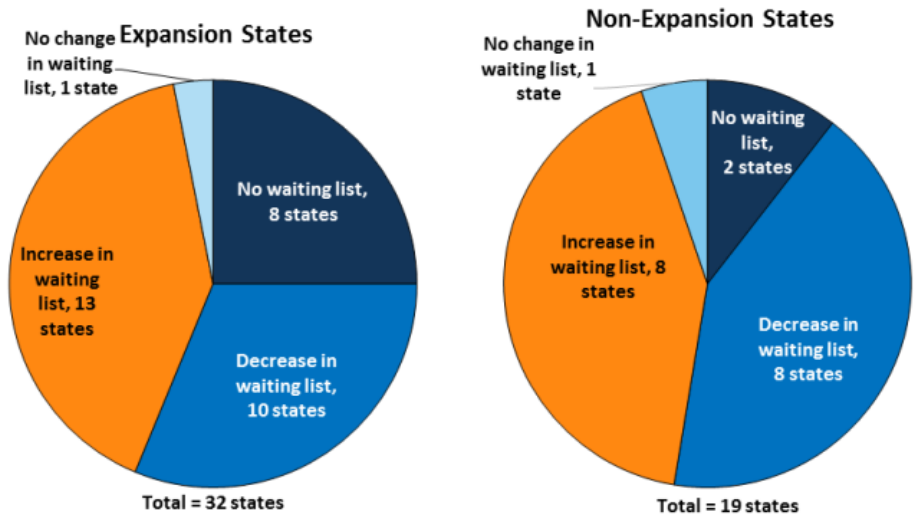
Waiting List Changes and State Adoption of ACA Medicaid Expansion

There does not appear to be a relationship between a state's Medicaid expansion statu and changes in its HCBS waiver waiting list between 2015 and 2016. Analysis of our survey data between 2014 and 2015 also does not support a relationship between a state's Medicaid expansion status and changes in its HCBS waiver waiting list.[14] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-14) HCBS waiver waiting lists pre-date the ACA's Medicaid expansion, which became effective in most states in 2014 (Figure 9).[15] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-15)

Most ACA expansion states (56%, or 18 of 32[16] (https://www.kff.org/medicaid/report/medicaid-home and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-16)) either have no HCBS waiver waiting list or had a decrease in their waiting list from 2015 to 2016 (Figure 10). Eight expansion states (Arizona, DC, Delaware, Hawaii, Massachusetts, Rhode Island, Vermont, and Washington) had no HCBS waiver waiting list in 2015 and 2016; seven of these states (all except Washington) also had no waiting list in 2014. Ten expansion states (Alaska, Colorado, Illinois, Indiana, Maryland, Minnesota, Montana, New Jersey, Pennsylvania, and West Virginia) experienced a decrease in their HCBS waiver waiting lists from 2015 to 2016. New Jersey completely cleared its waiting list between 2015 and 2016, and the other nine states experienced double digit percent decreases, ranging from -15% in Montana to -97% in Minnesota). Three of these states (Alaska, Indiana, and Pennsylvania) also experienced waiting list decreases from 2014 t 2015.

Figure 10

Changes in HCBS waiver waiting lists from 2015 to 2016, by ACA expansion status.



NOTE: Includes § 1915 (c) and § 1115 waivers.
SOURCE: Kaiser Family Foundation, *Medicaid Home and Community-Based Services Programs: 2013 Data Update* (Oct. 2016); Kaiser Family Foundation, *Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies* (Jan. 2017); Kaiser Family Foundation, Medicaid HCBS program survey conducted in 2016 (Jan. 2018).

Figure 10: Changes in HCBS waiver waiting lists from 2015 to 2016, by ACA expansion status.

Among states that experienced a waiver waiting list increase from 2015 to 2016, the average increase was lower in expansion states compared to non-expansion states (Figure 11). The average waiting list increase across 13 expansion states (Arkansas, California, Connecticut, Iowa, Kentucky, Louisiana, Michigan, North Dakota, New Hampshire, New Mexico, Nevada, Ohio, and Oregon) was 1,756 people and ranged from 3 people in North Dakota to 11,101 in Louisiana.[17] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-17) The average waiting list increase across eight non-expansion states (Alabama, Maine,[18] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-18) Mississippi, Nebraska, Oklahoma, South Carolina, Texas, and Utah) was 3,502 people and ranged from 302 people in Utah to 11,806people in Texas.

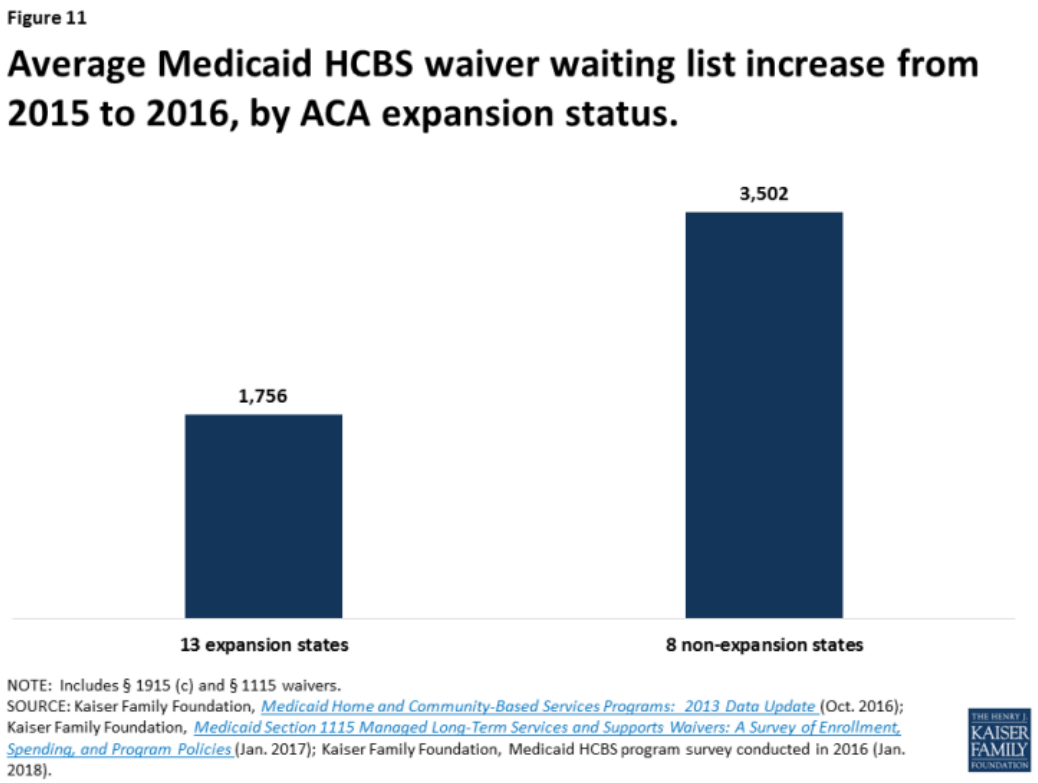


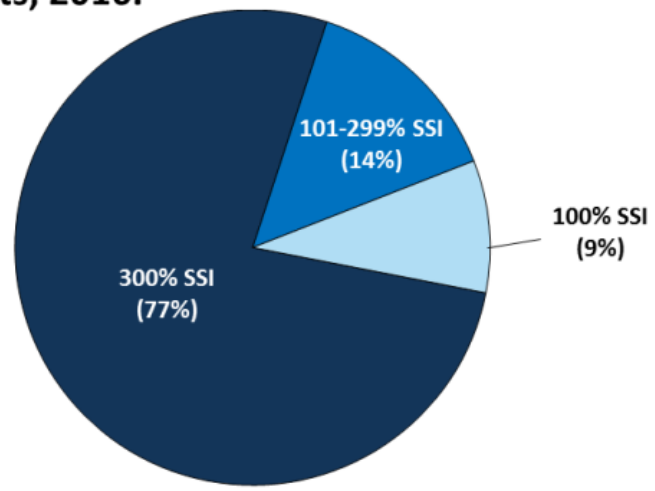
Figure 11: Average Medicaid HCBS waiver waiting list increase from 2015 to 2016, by ACA expansion status.

FINANCIAL ELIGIBILITY

Over three-quarters (77%, or 230 out of 298 waivers) of Section 1915 (c)/Section 1115 HCBS waivers set financial eligibility at the federal maximum (300% SSI or $2,199 per month for an individual in 2016) (Table 13 and Figure 12).[19] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-19) By contrast, 9 percent of Section 1915 (c)/1115 HCBS waivers set financial eligibility at the federal minimum (100% of SSI).

Figure 12

Medicaid § 1915(c) and § 1115 HCBS waiver financial eligibility limits, 2016.



Total = 298 reporting waivers

NOTE: In 2016, 300% of Supplemental Security Income (SSI) was $2,199 a month for an individual. Total includes 287 § 1915 (c) waivers and 11 § 1115 MLTSS waivers. SOURCE: Kaiser Family Foundation Medicaid HCBS program survey conducted in 2016; Kaiser Family Foundation, *Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies* (Jan. 2017).

Figure 12: Medicaid § 1915(c) and § 1115 HCBS waiver financial eligibility limits, 2016.

FUNCTIONAL ELIGIBILITY

Nearly all (94%, or 280 out of 298) Section 1915 (c)/Section 1115 HCBS waivers use the same functional eligibility criteria as are required for nursing facility eligibility. Only six Section 1915 (c) waivers (2% of all HCBS waivers) in four states (California, Idaho, North Dakota, and Oregon) used functional eligibility criteria that are more restrictive than those required for institutional care (no table shown). Functional eligibility criteria typically include the extent of assistance needed to perform self-care (such as eating, bathing, or dressing) and/or household activities (such as preparing meals or managing medications). Using the same functional eligibility for HCBS waivers and institutional care removes any potential bias in favor of institutional care, which can occur if an individual must have greater functional needs to receive HCBS than to receive institutional services.

COST CONTROLS

Eighty-two percent (42 of 51) of states used some form of cost controls in their Section 1915 (c) and/or Section 1115 HCBS waivers beyond the federal cost neutrality requirement[20] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-20) **in 2016.** Nineteen states used more than one type of cost control: 14 states used both fixed expenditure caps and hourly limits on services, four states used both fixed expenditure caps and geographic limits, and one state (Minnesota) used all three types of cost controls (Table 14). Another 18 states used fixed expenditure caps only, such as limiting the cost of HCBS to a

percentage of the nursing facility rate. Four states used hourly service limits only, such as day week, annual or lifetime limits on services such as personal care, respite, chore-homemaker, adult day, physical/occupational/speech therapies, and supported employment.

SELF-DIRECTION

Nearly all states (49 of 51) offer self-direction in their Section 1915 (c) and/or Section 1115 HCBS waivers in 2016. In nearly all states (47 responding), self-direction allows beneficiaries to select, train, and dismiss providers and set worker's schedules (Table 15). In most states, self-direction also allows beneficiaries to allocate their service budgets (35 states) and determine worker's pay rates (34 states). The majority of states offering self-direction (28 states) offer a choice of both agency-employed and independent providers. Twelve states offer only independent providers, seven states offer only agency providers, and two states dic not respond to this survey question. Twenty-nine states allow certain family members to be paid providers, typically those who are not the beneficiary's spouse or legally responsible relative (data not shown).

Department of Labor Direct Care Worker Minimum Wage and Overtime Rule Implementation

Fifteen states planned to restrict worker hours or make other policy changes in 2016, ir response to the U.S. Department of Labor (DOL) minimum wage and overtime rules, up from seven states that reported doing so in 2015. These states include California, Delaware, Georgia, Hawaii, Iowa, Kansas, Kentucky, New Hampshire, New Mexico, Oklahoma, Oregon, Tennessee, Washington, Wisconsin, and Wyoming. DOL extended the Fair Labor Standards Act minimum wage and overtime rules to most direct care workers, such as certified nursing assistants, home health aides, personal care aides, and other caregivers, wh previously were exempt from those requirements; the new rules took effect in 2015.[21] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-21) CMS policy guidance issued in 2014 anticipated that the new DOL rules could affect self-directed Medicai HCBS and observed that "many states will need to develop policies and consider programmatic changes to address the costs related to overtime and/or worker time spent traveling between worksites (i.e., individuals' homes), to avoid or minimize negative impacts tc individual [service] budgets, and to preserve the ability of individuals to self-direct services an supports effectively."[22] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote 247231-22)

Among the states reporting 2016 policy changes in response to the DOL rule, five (Iowa, New Mexico, Oklahoma, Wisconsin, and Wyoming) limited worker hours to 40 per week Other states allow overtime subject to certain conditions. For example, two states allowed providers with a history of overtime hours to work a limited amount of overtime (up to 50 hours per week in Oregon, and up to 65 hours per week in Washington), while one state (Georgia) allows overtime only if necessary to avoid nursing facility placement.

Ten states reported budgeting state funds for worker overtime and/or travel time pay as a result of the DOL rule. Specifically, seven states (Alabama, California, Illinois, Massachusetts, Nebraska, South Carolina, and Washington) budgeted funds for direct care worker overtime and travel pay in fiscal year 2017, and three states (Kentucky, Pennsylvania, and Wisconsin) had budgeted funds for overtime only.

QUALITY MEASURES AND OVERSIGHT

All states reported having at least one HCBS waiver quality measure in place in 2016. Forty-eight states measure beneficiary quality of life through tools such as the National Core Indicators – Aging and Disability (NCI-AD) survey,[23] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-23) the CAHPS HCBS survey,[24] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-24) and other consumer satisfaction surveys. Thirty-three states have quality measures related to community integration based on the NCI-AD survey, care plan reviews to evaluate person-centeredness, or monitoring beneficiary choice of service providers. Nineteen states use LTSS rebalancing measures drawing from annual needs assessment data or the Money Follows the Person rebalancing benchmarks. For example, Tennessee's LTSS rebalancing measures include: the number of enrollees receiving nursing facility services or HCBS at a point in time and over 12 months; HCBS and nursing facility expenditures for 12 months and as a percentage of total LTSS spending; average annual per person HCBS and nursing facility expenditures; average annual length of stay in nursing facilities and HCBS; percent of new LTSS beneficiaries admitted to nursing facilities annually; and annual number of nursing facility to HCBS transitions.[25] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-25) HCBS quality measures vary by state and sometimes vary by waiver within a state. CMS's 2016 Medicaid managed care rule requires states that provide MLTSS to identify standard performance measures related to quality of life, rebalancing, and community integration for health plan contracts beginning on or after July 1, 2017.[26] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-26)

Forty-two states reporting having an ombudsman program, typically as part of state government (34 states), to assist Medicaid beneficiaries receiving HCBS. Ombudsman programs may provide enrollment options counseling, assist beneficiaries with health plan appeals, offer information about state fair hearings, track beneficiary complaints, train health plans and providers about community-based services and supports that can be linked with Medicaid-covered services, and report data and systemic issues to states. The 2016 Medicaid managed care rule requires states using capitated MLTSS to offer an independent beneficiary support system, in plan contracts beginning on or after July 1, 2018, that provides the following services for people who use or wish to use LTSS: (1) an access point for complaints and concerns; (2) education on enrollee rights and responsibilities; (3) assistance in navigating the grievance and appeals process; and (4) review and oversight of data to guide the state in

identifying and resolving systemic LTSS issues.[27] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-27)

WAIVER CONSOLIDATION

Sixteen states reported plans to consolidate multiple Section 1915 (c) HCBS waivers or move those services to another Medicaid authority; these changes would affect 26 existing Section 1915 (c) waivers. These states include: California, Colorado, Connecticut, Delaware, Florida, Indiana, Michigan, Missouri, Nebraska, New York, Ohio, South Carolina, Tennessee, Utah, Virginia, and Wisconsin. Children with I/DD (10 states) and adults with I/DD (7 states) are the target populations most often affected by these changes. Some states, such as Michigan,[28] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-28) New York,[29] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-29) an Virginia,[30] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a 50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-30) are planning to consolidate multiple Section 1915 (c) waivers into a single Section 1115 waiver tha would both authorize HCBS and require capitated managed care enrollment.[31] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-31) If approved by CMS, Michigan and Virginia would join the 11 other states (including New York, which proposes adding new populations) that offer some or all home and community-based waiver services through Section 1115 MLTSS waivers instead of Section 1915 (c) (Figure 13).[32] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-32) Other states are moving certain HCBS from Section 1915 (c) waiver to Medicaid state plan authority. For example, South Carolina and Utah are phasing out their Section 1915 (c) waivers that serve children with autism and instead offering those services as part of their state plan benefit package.

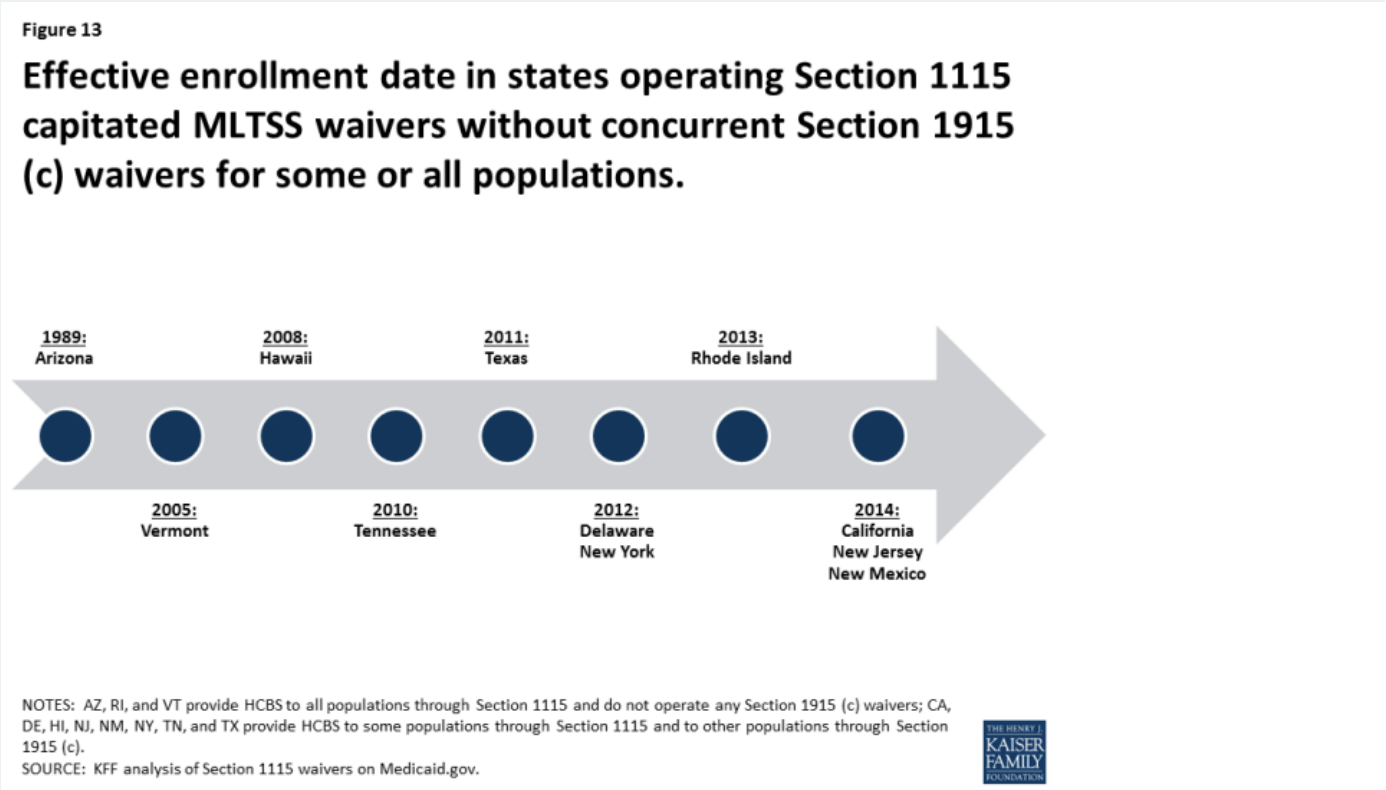


Figure 13: Effective enrollment date in states operating Section 1115 capitated MLTSS waivers without concurrent Section 1915 (c) waivers for some or all populations.

HOME AND COMMUNITY-BASED SETTINGS RULE IMPLEMENTATION

States were further along in the process of identifying policy changes necessary to com into compliance with CMS's home and community-based settings rule in 2016 comparec to 2015, although many states were still evaluating settings. CMS's January 2014 rule defines the qualities of residential and non-residential settings in which Medicaid-funded HCBS can be provided.[33] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote247231-33) To be considered community-based, settings must support an individual's full acces to the greater community; be selected by the individual from options including non-disability specific settings; ensure individual privacy, dignity, respect and freedom from coercion or restraint; optimize individual autonomy in making life choices; and facilitate individual choice regarding services and providers. Additional criteria apply to provider-owned or controlled settings. In May, 2017, CMS extended the state compliance deadline by three years, to March, 2022, but retained the March, 2019 deadline for states to submit transition plans.[34] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-34) As of January 3, 2018, seven states (Arkansas, Delaware, DC, Kentucky, Oklahoma, Tennessee, and Washington) had received final CMS approval on their transition plans.[35] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-35)

Forty-two states reported that they anticipated having to change state rules or policies to come into compliance with the settings rule in 2016, up from 21 states in 2015. These states include: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia Hawaii, Iowa, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming. Specifically, 35 states have identified some settings that will have to be modified in some way to continue to be used for Medicaid-funded HCBS under the settings rule (up from 13 states in 2015). Additionally, 16 states identified settings that cannot be modified to meet the settings rule and consequently will require beneficiaries to be relocated to continue receiving Medicaid-funded HCBS (up from 2 states in 2015).

Twenty-eight states plan to submit information to the HHS Secretary to overcome the rule's presumption that a specific setting is institutional so that Medicaid-funded HCBS can continue to be provided there (up from 11 states in 2015). The settings rule presumes that certain settings are not community-based because they have institutional qualities, such as those in a facility that provides inpatient treatment, those on the grounds of or adjacent to a public institution, and those that have the effect of isolating individuals from the broader community. The Secretary can overcome the institutional presumption for these settings by applying heightened scrutiny based on information submitted by the state. Twenty-two states have identified settings that are presumed institutional because they effectively isolate beneficiaries (up from 10 states in 2015).

State Plan Home Health and Personal Care Service Policies

Unlike HCBS waivers, state cannot cap enrollment or place geographic limits on home health or personal care state plan services. However, federal Medicaid rules allow states to use certain cost-containment strategies for state plan services. States also can apply policies that affect the type of services received under these benefits. We surveyed all state Medicaid programs in 2016 to report on key policy areas, including scope of benefits, self-direction, cost controls, and provider policies.

SCOPE OF BENEFITS

Most states offer optional therapy services under their home health state plan benefits. All state Medicaid programs must offer home health services, including nursing services, home health aide services, and medical supplies, equipment and appliances. States can choose to also offer physical therapy, occupational therapy, and speech pathology as part of their home health programs, and most (37 states) do. In addition, 15 states provide assistance with household activities (such as meal preparation or medication management) as part of their home health benefit, in addition to assistance with self-care.

States provide a variety of services in a variety of settings under their state plan personal care benefits. Thirty (of 31) states include assistance with household activities, 17 states provide transportation, 15 states cover cueing or monitoring, and 11 states cover tasks

delegated by a nurse, such as injections. In addition to the beneficiary's residence, 22 states offer personal care services at a beneficiary's work site, 15 states provide services at residential care, foster care or assisted living facilities, and 17 states provide services in the community outside of a home or work setting.

SELF-DIRECTION

A majority of states (20 out of 31) allowed self-direction in their personal care state plan services programs, while few (6 out of 51) states did so for their home health state plan services programs (Table 14). The state with the highest personal care services self-direction enrollment was California, serving 470,339 beneficiaries in 2016. Five states (CA, FL, OR, TX, and WI) used the Section 1915 (j) state plan option to offer self-directed personal assistance services in 2016, serving 20,095 individuals and spending $194 million. Fifteen states offer only agency-directed personal care services, nine states use both agency-directed and independent providers, and two states offer only independent personal care providers. The remaining five states did not respond to this survey question.

COST CONTROLS

The majority of states applied cost controls to state plan home health and personal care services in 2016. Sixty-three percent (32 of 51 states) applied cost controls, such as expenditure caps or hourly limits, to their home health state plan services. Of these, 26 states used hourly limits only, three states used expenditure caps only, and three states used both hourly limits and expenditure caps (Table 14). Sixty-one percent (19 of 31 states) applied cost controls to their personal care state plan services. Of these, 17 states used hourly limits only, state (Missouri) used expenditure caps only, and 1 state (Florida) used both types of cost controls (Table 14).

PROVIDER POLICIES

Criminal Background Checks

Nearly all states require personal care and home health providers to undergo criminal background checks. These include all but two (Montana and North Dakota) personal care state plan option states, and nearly all states (30 of 40) responding to this home health survey question.

Training

Most states require training for personal care providers, while few have training requirements for home health aides. Specifically, 65% (17 of 26 responding) states required formal training for personal care attendants, and 73% (19 of 26) had requirements for attendant supervision. Eighteen percent (9 of 51) of states require home health aide training, including West Virginia, which requires 75 hours of one-time training plus twelve hours of continuing education each year.

Reimbursement Rates

The average home health agency reimbursement rate decreased slightly from 2015 to 2016, while the average personal care agency reimbursement rate increased slightly. On average, states paid home health agencies $92.52 per visit in 2016, compared to $93.93 per visit in 2015. The average personal care agency rate was $19.01 per hour in 2016, and $18.82 per hour in 2015. In states that paid registered nurses or home health aides directly o mandated their reimbursement rates, the average rate per home health visit was $83.29 and $42.56, respectively (Table 16). In states that paid personal care providers directly or mandated their reimbursement rates, the average hourly rate was $14.32 (Table 16).

Enrollment, Spending, and Policies in Other Medicaid HCBS Authorities in 2016

To provide a more complete snapshot of Medicaid HCBS across program authorities, this year's survey asked states about their use of the Section 1915 (i) HCBS state plan option and the Community First Choice state plan option.

Section 1915 (i) HCBS State Plan Option

Eighteen states used the Section 1915 (i) state plan option to provide HCBS in 2016. These states include: California, Colorado, Connecticut, Delaware, District of Columbia, Florida Idaho, Indiana, Iowa, Maryland, Michigan, Mississippi, Montana, Nevada, North Dakota, Oregon, Texas, and Wisconsin. Almost 62,000 individuals received Section 1915 (i) HCBS (in 8 states reporting this data: CA, CT, DC, DE, ID, IN, MS & NV), and $237,007,226 was spent on these services (7 states reporting: CA, CT, DE, ID, IN, MS & NV). Section 1915 (i) allows states to offer HCBS as part of their Medicaid state plan benefit package instead of through a waiver. Unlike waivers, states are not permitted to cap enrollment or maintain a waiting list for Section 1915 (i) HCBS.

Most Section 1915 (i) states (15) set financial eligibility at 150% FPL, while three states (Idaho, Indiana, and Maryland) extend financial eligibility to 300% SSI. Both Idaho and Indiana operate more than one 1915 (i) program (targeted to different populations). Under Section 1915 (i), states can cover (1) people up to 150% FPL with no asset limit who meet functional eligibility criteria; and/or (2) people up to 300% SSI who would be eligible for Medicaid under an existing HCBS waiver. Functional eligibility under Section 1915 (i) requires beneficiaries to have needs that are less than what is required to qualify for an institutional level of care, and states can manage enrollment by restricting functional eligibility criteria if the state will exceed its anticipated number of beneficiaries served.

Only one state (Indiana) uses Section 1915 (i) as an independent Medicaid coverage pathway. Indiana's Section 1915 (i) benefit targeted to people with mental illness allows individuals who are not otherwise eligible to gain Medicaid coverage.[36]
(https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-

survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-36) The other 17 states use Section 1915 (i) to authorize HCBS but require enrollees to be otherwise eligible for Medicaid.

States are targeting specific populations under Section 1915 (i). Of the 18 states offering HCBS through Section 1915 (i), eight states serve people with mental illness, five states serve people with I/DD, and five states serve seniors and/or adults with physical disabilities.

Section 1915 (k) Community First Choice State Plan Option

Eight states (CA, CT, MD, MT, NY, OR, TX, and WA) are offering attendant care services and supports through the Community First Choice (CFC) state plan option as of 2016. CFC is a Medicaid HCBS option added by the ACA and includes six percent enhanced federal matching funds. Over 353,000 individuals received CFC services (7 states reporting: CA, CT, MD, MT, OR, TX and WA), and $8.2 billion was spent on these services (6 states reporting: CA, MD, MT, OR, TX and WA) in 2016. California accounted for the largest number of CFC spendin and enrollment, spending $5 billion on 212,688 individuals. Five states (CT, MD, MT, NY[37] (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/view/footnotes/#footnote-247231-37) and WA) set CFC financial eligibility at 150% FPL, and three states (CA, OR and TX) extend financial eligibility above 150% FPL.

Conclusion

Over the past three decades, increased access to Medicaid HCBS has resulted in greater enrollment in and spending on these services. The size and scope of Medicaid HCBS programs continues to vary across states. Section 1915 (c) waivers continue to account for th majority of HCBS enrollment and spending. While working to expand beneficiary access to HCBS, states also have been implementing the ACA's Medicaid expansion. The data do not support a relationship between changes in HCBS enrollment or waiting lists and a state's Medicaid expansion status. States also continue to focus on policy changes to implement federal regulatory requirements, including the MLTSS provisions of the Medicaid managed care rule, the DOL minimum wage and overtime rule, and the home and community-based settings rule, with most states reporting policy changes in these areas. As the population age and medical advances continue to emerge to support people with disabilities living longer anc independently in the community, stakeholder interest in state trends in Medicaid HCBS enrollment, spending, and program policies is likely to continue.

‹ INTRODUCTION (HTTPS://WWW.KFF.ORG/REPORT-SECTION/MEDICAID-HOME-AND-COMMUNITY-BASED-SERVICES-RESULTS-FROM-A-50-STATE-SURVEY-OF-ENROLLMENT-SPENDING-AND-PROGRAM-POLICIES-INTRODUCTION/)

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