Order Code RS22448
May 26, 2006

Medicaid's Home and Community-Based Services State Plan Option: Section 6086 of the Deficit Reduction Act of 2005

Karen Tritz
Analyst in Social Legislation
Domestic Social Policy Division

Summary

Section 6086 of the Deficit Reduction Act of 2005, (DRA, P.L. 109-171) established a new optional Medicaid benefit that allows states to cover home and community-based, long-term care services (HCBS) for Medicaid beneficiaries with disabilities or chronic conditions, starting in January 2007. Prior to the enactment of DRA, states were generally required to receive a Section 1915(c) home and community-based waiver to cover these services. However, this new HCBS benefit differs in several ways from the structure of both current Medicaid state plan benefits and the Section 1915(c) waiver program. For example, unlike other Medicaid state plan benefits, this benefit is limited to individuals whose income does not exceed 150% of the federal poverty level. This report outlines the requirements of the new Medicaid home and community-based services benefit, and compares key features of this benefit with other Medicaid state plan benefits and the Section 1915(c) waiver program. This report will be updated to reflect significant policy or programmatic changes.

Background

Medicaid has covered home and community-based, long-term care services since the inception of the program in 1965 through various service categories. Home and community-based, long-term care services refer to a broad range of health and supportive services (provided in a non-institutional setting) that are needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or chronic condition resulting in functional impairment(s) for an extended period of time.

Starting in 1965, Medicaid allowed states to cover a range of *home health services* and required states to cover those services for individuals who would otherwise require nursing facility services. Home health services include skilled nursing, aide services, medical equipment and supplies, and, in some cases, therapy. States were also permitted to cover *rehabilitation* and *private duty nursing services.* Rehabilitation can include a broad range of medical or remedial services recommended by a physician or other

licensed practitioner to reduce the degree of physical or mental disability and restore functioning.[1] Private duty nursing is skilled nursing care for individuals who generally require a level of care beyond what is available under the home health or personal care benefits.

Over time, Congress and the Centers for Medicare and Medicaid Services (CMS) have allowed states to cover other types of home and community-based services as optional benefits under the Medicaid state plan such as *personal care* and *case management services*.[2] The personal care benefit was added as an optional Medicaid benefit in 1978, and includes assistance with activities of daily living, (e.g., dressing, bathing, eating).[3] The case management benefit was added as an optional benefit in 1986, and includes services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational, and other services.

In addition to the Medicaid state plan benefits, in 1981 Congress authorized the home and community-based (HCBS) waiver program under Section 1915(c) of the Social Security Act. The HCBS waiver program gives states the ability to cover a wide range of home and community-based services for individuals who would otherwise require the level of care in an institution — i.e., a nursing facility, hospital, or intermediate care facility for individuals with mental retardation (ICF/MR). Under an HCBS waiver, the Secretary is permitted to waive Medicaid's "statewideness" requirement to allow states to cover HCBS services in a limited geographic area. The Secretary may also waive the requirement that services be comparable in amount, duration, or scope for individuals in particular eligibility categories. Under an HCBS waiver, states may limit the number of individuals served and target certain populations (e.g., individuals with developmental disabilities, individuals with a brain injury, the aged). To receive approval for the HCBS waiver, states have to meet certain other requirements such as a cost-effectiveness test — which requires that on average Medicaid expenditures for waiver participants not exceed the cost that would have been spent if these individuals were residing in an institution.

All states cover some Medicaid home and community-based services for certain groups of Medicaid beneficiaries. **Table 1** below summarizes the number of states offering specific Medicaid benefits, the numbers of beneficiaries receiving specific services, and the total expenditures. For example, 45 states and the District of Columbia use the Medicaid rehabilitation state plan benefit to provide services for individuals with mental illness. Under the HCBS waiver program, 49 states and the District of Columbia provide at least one waiver for individuals who are elderly and/or younger adults with physical disabilities, and one waiver for individuals with mental retardation or developmental disabilities. Some states also use the HCBS waiver program to provide services for other groups such as individuals with HIV/AIDS or brain injury.

---

[1] Section 1905(a)(13) of the Social Security Act.

[2] The Medicaid state plan is the document states submit to the federal government for approval that describes the eligibility groups and covered services.

[3] 43 FR 45228, 9/29/78, effective 10/1/78. Congress added personal care services as a covered Medicaid service to the Social Security Act in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

Table 1. Medicaid's Coverage of Home and Community-Based Long-Term Care Services: Implementation by States, Number of Beneficiaries, and Total Expenditures

	Number of states (and D.C.) covering benefit in 2005	Number of Medicaid beneficiaries, FY2003 (in thousands)	Total expenditures, FY2003 (in millions)
Home health	51	1,107	$2,894
Rehabilitation	51	1,520	$4,961
Private duty nursing	27	32	$496.8
Personal care	36	634	$7,044
Case management	48	2,363	$2,756
HCBS waivers	50	919	$18,855

Source: CRS Analysis of CMS Medicaid Statistical Information System (MSIS), FY2003 and [http://www.cms.hhs.gov/MLNProducts/downloads/MedGlance05.pdf].

Note: For additional information about state-specific coverage of Medicaid state plan services, see [http://www.cms.hhs.gov/MLNProducts/downloads/MedGlance05.pdf]. For state-specific information on Section 1915(c) home and community-based waiver programs, see [http://www.nasmd.org/waivers/1915cdb.htm].

Home and Community-Based Services State Plan Option: Section 6086 of the Deficit Reduction Act

Section 6086 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) established a new optional benefit under the Medicaid state plan that allows states to cover certain home and community-based services without requiring a HCBS waiver. The requirements of this new optional benefit differ in many ways from other Medicaid state plan benefits (e.g., home health and personal care) and the Section 1915(c) waiver program. **Table 2** compares key features of the new HCBS benefit with existing Medicaid program authorities.

CMS is in the process of developing guidance and regulations for states to implement the HCBS state plan option. CMS expects that state guidance will be released in the summer of 2006, and interim final regulations will be published in late 2006.

It is too soon to determine how many states will choose to cover this new Medicaid benefit, how the new benefit will be designed (e.g., covered services, the target group), and how this option will be used relative to existing home and community-based services. For example, states that currently do not cover personal care may use the new HCBS option to cover personal care, since enrollment under this new benefit can be capped. Other states may use this benefit to provide services to individuals who generally do *not* receive HCBS waiver services, such as individuals with severe and persistent mental illness. A further exploration of these issues will be addressed in future reports as additional information becomes available.

Table 2. Comparison of Medicaid Benefits under State Plan, Home and Community-Based Waiver, and the Home and Community-Based (HCBS) Benefit, (Section 6086 of the Deficit Reduction Act of 2005)

Feature	Medicaid State Plan Benefits	Section 1915(c) Home and Community-Based Waiver	Section 6086: Optional HCBS Benefit Under DRA
Federal approval of benefit	States submit a state plan amendment (SPA) usually based on a pre-print, and provide an estimate of total expenditures. Federal approval of the SPA is not time-limited. Certain changes to a Medicaid benefit may require an amendment to the SPA.	States submit a waiver application with significant detail that justifies the cost-neutrality of the waiver. (See below.) Initial waiver approval is for a three-year period. Subsequent waiver renewals may be approved for a five-year time period.	This new benefit will likely require a SPA amendment in which the state describes what services and population the proposed benefit would cover. Federal approval of the SPA is not time-limited. Certain changes to a Medicaid benefit may required an amendment to the SPA.
Allowable scope of service	The Medicaid state plan allows states to cover a variety of acute and long-term care benefits both in institutional settings (e.g., nursing facilities, and hospitals), and in home and community-based settings (e.g., home health, case management). Generally, the scope of a service must follow broad parameters outlined in federal law. When a state submits a SPA, CMS interprets whether a particular activity meets this broad purpose.	The Section 1915(c) provision specifically allows states to cover case management, homemaker/home health aide services, personal care, adult day health, habilitation, respite care, 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. However, the Secretary may approve other services on a case-by-case basis.	This benefit allows states to cover those HCBS waiver services that are specifically listed in Section 1915(c) of the statute. The Secretary may not approve other state-requested services on a case-by-case basis.
Availability of the benefit	Medicaid state plan benefits are generally available statewide and are not limited to target groups.	HCBS waivers can be made available on a less-than-statewide basis, and are only available for certain target groups.	The new benefit can be made available on a less-than-statewide basis, for individuals who meet state-specified, *needs-based* criteria. (See below.)
Projected enrollment/ limits on number served	States are not required to report the projected enrollment in a particular benefit, and are not permitted to limit the number of individuals who can receive these services.	States project the enrollment in the HCBS waiver (within the cost-neutrality provision), and can limit the number of individuals who can receive services.	States will project enrollment in the benefit, and can limit the number of individuals who can receive these services.

Feature	Medicaid State Plan Benefits	Section 1915(c) Home and Community-Based Waiver	Section 6086: Optional HCBS Benefit Under DRA
Requirement for cost-neutrality	Not applicable (state plan services are not subject to cost-neutrality).	Under a HCBS waiver, the average per capita expenditure for medical assistance for HCBS recipients may not exceed the average per capita expenditures that the state would have spent in an institution. States may apply the per capita expenditure limit to each individual, or apply the limit as an aggregate cap across all waiver participants. (This calculation includes the costs of other Medicaid state plan services which the individual may be eligible for such as inpatient hospital, etc.)	Not applicable (state plan services are not subject to cost-neutrality).
Eligibility criteria	Those who meet functional and financial criteria associated with a Medicaid eligibility group. States may cover Medicaid eligible individuals under various income and resource standards such as the following: — Institutional group (300% of the Supplemental Security Income (SSI) federal benefit rate, $1,809/month in 2006, about 222% of the federal poverty level (FPL)). — Medically Needy group whereby an individual's income is reduced to a state-specified standard by deducting medical expenses. — Other eligibility groups (e.g., SSI). States may set additional functional eligibility criteria to receive specific services that ensure medical necessity; see below.	Those who are Medicaid eligible for a group that the state has designated qualify for an HCBS waiver (e.g., institutional group, medically needy), who meet the institutional level of care, *and* who are part of the HCBS waiver target group (e.g., individuals with developmental disabilities, the aged, those with HIV/AIDS, etc). This benefit is often a pathway to Medicaid eligibility for community-dwelling individuals with disabilities or the elderly who qualify for Medicaid because they meet the eligibility criteria for the institutional group (300% of SSI) which is generally a higher income threshold than other Medicaid eligibility categories.	Those who are Medicaid-eligible, who meet the needs-based criteria (discussed below) and have income below 150% of FPL, ($1,225/month for an individual in 2006). Unlike the HCBS waiver, this benefit does not confer Medicaid eligibility for individuals who meet eligibility criteria for the institutional group (300% of SSI).

Feature	Medicaid State Plan Benefits	Section 1915(c) Home and Community-Based Waiver	Section 6086: Optional HCBS Benefit Under DRA
Functional eligibility criteria for receiving services	The state may require that an individual meet a certain level of care to be eligible for a particular service. Some services require an institutional level of care, (e.g., nursing facility). Other services may require a specific level of care; or, at the very least, that the service must be medically necessary. For example, a state may require that an individual need assistance with activities of daily living (ADL) to receive personal care services.	Persons eligible for waiver services must require the level of care provided in a hospital, nursing home, or ICF/MR. A state may choose (with the Secretary's approval) the specific criteria to be used to determine whether an individual requires the level of care provided in a hospital, nursing home, or ICF/MR.	Individuals are required to meet the state-established needs-based criteria which *may* take into account the need for assistance with 2 or more activities of daily living, and other risk factors. The needs-based criteria for the HCBS option must be less stringent than the level of care required for an institution (i.e., nursing facility, hospital, or intermediate care facility for persons with mental retardation (ICF/MR)). States can continue to receive federal Medicaid funds for individuals already receiving institutional-level benefits. If enrollment exceeds what the state projects, a state may modify the needs-based criteria. The statute outlines certain conditions that this modification must meet.
Written individualized plan of care	Medicaid state plan benefits do not usually require that an individual have a written plan of care. However, a provider likely keeps service record documentation.	HCBS waiver services that are approved by the Secretary must be provided according to a written plan of care for each individual. Medicaid law is not specific as to how the evaluation and assessment are conducted.	There must be an independent evaluation and assessment to establish a written, individualized plan of care. The statute outlines specific criteria that must be met. For example, there must be a face-to-face evaluation of each individual, and an examination of the individual's relevant history and medical records.
Cost-sharing and post-eligibility treatment of income	For individuals who qualify for Medicaid through institutional rules, all income in excess of certain allowances is paid toward the cost of their care (known as "post-eligibility treatment of income"). In addition, for service-specific cost-sharing general Medicaid rules apply.	Depending upon the beneficiary's Medicaid eligibility category, a waiver participant may be subject to post-eligibility treatment of income.	Post-eligibility treatment of income does not apply. The state may require cost-sharing charges for this service, subject to Medicaid's general cost-sharing rules.