Medicaid Coverage of Long-Term Services and Supports

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Summary

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time. Medicaid plays a key role in covering LTSS to aged and disabled individuals. As the largest single payer of LTSS in the United States, federal and state Medicaid spending accounted for $149.4 billion or 42.5% of all LTSS expenditures in 2015 ($351.8 billion). LTSS are also a substantial portion of spending within the Medicaid program relative to the population served, accounting for 31% of all Medicaid spending in 2015. Of the 68.5 million total enrolled Medicaid population, an estimated 4.1 million (or 5.9%) received LTSS in FY2013.

Medicaid funds LTSS for eligible beneficiaries in both institutional and home and community-based settings, though the portfolio of services offered differs substantially by state. Moreover, states are required to offer certain Medicaid institutional services to eligible beneficiaries, while the majority of Medicaid home and community-based services (HCBS) are optional for states. In recent decades, federal authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include HCBS. As a result, the share of Medicaid LTSS spending for HCBS has nearly tripled, accounting for 18% of Medicaid LTSS spending in 1995 to over half (53%) of total Medicaid LTSS spending in FY2014.

States now have a broad range of coverage options to select from when designing their LTSS programs. In general, Medicaid law provides states with two broad authorities, which either cover certain LTSS as a benefit under the Medicaid state plan or cover home and community-based LTSS through a waiver program which permits states to disregard certain Medicaid requirements in the provision of these services, subject to approval. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established or extended several Medicaid state plan options and grant activities to enhance or expand states' LTSS delivery systems. Given the range of available coverage options, states continue to enhance or expand their LTSS delivery systems to cover additional services or target services to specific populations with a focus on HCBS. In FY2016 and FY2017, most states reported activities to expand HCBS (46 and 47 states, respectively), which include expanding Section 1915(c) HCBS waiver authority programs or the Section 1915(i) HCBS state plan option, among other programmatic changes.

This report provides a description of the various statutory authorities that either require or otherwise allow states to cover LTSS under Medicaid. **Appendix A** provides a brief legislative history of Medicaid LTSS from Medicaid's enactment and initial coverage requirements for institutional care through the evolution of HCBS options available to states. A discussion of changes to Medicaid made by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) with respect to LTSS coverage options is also provided. The tables in **Appendix B** provide state information about coverage of Medicaid state plan optional benefits.

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Introduction

Medicaid plays a key role in covering long-term services and supports (LTSS) to eligible aged and disabled individuals. As the largest single payer of LTSS in the United States, Medicaid LTSS spending in 2015 (combined federal and state) totaled $149.4 billion and accounted for 42.5% of all LTSS expenditures ($351.8 billion).[1] LTSS are also a substantial portion of spending within the Medicaid program relative to those served. In 2015, Medicaid LTSS accounted for 31% of all Medicaid spending despite the fact that LTSS recipients represent a relatively small share of the total Medicaid population.[2] An estimated 4.1 million Medicaid beneficiaries (or 5.9%) of the 68.5 million total enrolled Medicaid population received LTSS in FY2013.[3]

What Are Long-Term Services and Supports?

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time.

Medicaid funds LTSS for eligible beneficiaries in both institutional settings and home and community-based settings, though the portfolio of services offered differs substantially by state. Federal law requires that state Medicaid programs cover certain LTSS for eligible beneficiaries, such as nursing facility care. However, states have a range of options that allow LTSS coverage of home and community-based services (HCBS) for Medicaid beneficiaries based on need, and that allow states to target such coverage to particular groups of individuals (i.e., older adults and individuals with physical disabilities, or individuals with a specific disease or condition such as HIV/AIDS). These flexibilities under Medicaid law have led to widespread variation in state Medicaid LTSS benefit packages offered to elderly and disabled individuals.

One important issue for Medicaid LTSS coverage is its perceived bias in favor of institutional care. The original 1965 Medicaid law established that eligible Medicaid beneficiaries are entitled to nursing facility care. In more recent decades, federal Medicaid statutory authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include optional HCBS. For example, the addition of the Section 1915(c) HCBS waiver to Medicaid law in 1981[4] and subsequent statutory amendments that created new Medicaid state plan benefit options have allowed states to further the provision of HCBS. Subsequent legislative and administrative activities to expand Medicaid HCBS, in part, were prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,[5] which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). As a result, states have a broad range of coverage options to select from when designing their LTSS programs. Moreover, the share of Medicaid LTSS spending for HCBS has

[1] For further information on LTSS financing, see CRS In Focus IF10343, *Who Pays for Long-Term Services and Supports?*.

[2] Ibid.

[3] Medicaid and CHIP Payment and Access Commission (MACPAC), *MACStats: Medicaid and CHIP Data Book*, December 2016, p. 53, https://www.macpac.gov/wp-content/uploads/2016/12/MACStats_DataBook_Dec2016.pdf.

[4] Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

[5] 527 U.S. 581 (1999).

nearly tripled over time, from 18% of Medicaid LTSS spending in FY1995 to over half (53%) of total Medicaid LTSS spending in FY2014.[6]

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) further added to the range of options available to states that want to pursue HCBS coverage expansion. Specifically, the ACA established or extended several Medicaid state plan options (Section 1915(i) HCBS state plan option and Section 1915(k) Community First Choice state plan option). In FY2016 and FY2017, a majority of states reported activities to expand HCBS in 46 and 47 states, respectively.[7] Most states reported using Section 1915(c) HCBS waiver programs or the Section 1915(i) HCBS state plan option to expand their HCBS offerings (42 states in FY2016 and 41 states in FY2017). About half of states that reported activities to expand HCBS plan to implement or expand the financing and delivery of Medicaid LTSS through managed care arrangements (19 states in FY2016 and 18 states in FY2017). A fewer number of states reported closing institutional settings or downsizing beds in these settings in an effort to expand community placements (14 states in FY2016 and 9 states in FY2017).

This report provides a description of the various statutory authorities and other legislative provisions that either require or otherwise allow states to cover LTSS under Medicaid. The report's **Appendix A** provides a brief legislative history of Medicaid LTSS from Medicaid's enactment and initial coverage requirements for institutional care through the evolution of HCBS options available to states. A discussion of ACA's changes to Medicaid law with respect to Medicaid LTSS coverage options is also provided. The **Appendix B** tables provide state information about coverage of Medicaid state plan optional benefits and certain grant programs to expand Medicaid HCBS.

Medicaid LTSS Coverage

Medicaid is a means-tested individual entitlement program which finances the delivery of health care and LTSS to certain low-income individuals. Established under Title XIX of the Social Security Act (SSA), the Medicaid program is state-operated, within broad federal guidelines, and is funded by both state and federal revenues.[8] The federal share for Medicaid service costs is determined by the federal medical assistance percentage (FMAP). FMAP rates are based on a formula that provides higher federal reimbursement to states with lower per capita income relative to the national average (and vice versa).[9] Historically, to qualify for Medicaid individuals must meet certain categorical and financial requirements. To qualify for Medicaid LTSS, individuals must also meet state-defined level-of-care criteria.[10]

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[6] Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

[7] Vernon K. Smith, K. Gifford, E. Ellis, et al. *Implementing Coverage and Payment Initiatives: Results from a 60-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*, Kaiser Family Foundation and the National Association of Medical Directors, October 13, 2016, p. 44, at http://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives.

[8] For more information on Medicaid see, CRS Report R43357, *Medicaid: An Overview*.

[9] For further information, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[10] To define level-of-care criteria, states may use "functional" criteria such as an individual's ability to perform certain Activities of Daily Living (ADLs, e.g., eating, bathing, dressing, and walking) or to perform certain Instrumental Activities of Daily Living (IADLs, e.g., shopping, housework, and meal preparation) that allow an individual to live independently in the community. Other states may use "clinical" level-of-care criteria that include diagnosis of an illness, injury, disability or other medical condition, treatment and medications, and cognitive status, among other (continued...)

State Medicaid LTSS delivery systems include the provision of services in two types of settings: (1) services provided in institutional settings, such as nursing facilities, and (2) services and supports provided in home and community-based settings, such as private homes, adult day facilities, or assisted living facilities.[11] States are required to offer certain Medicaid institutional services. However, the majority of HCBS offerings are optional for states.

Medicaid law and other provisions in SSA contain several authorities that permit states to offer LTSS to individuals in need of such services. In general, Medicaid law provides states with two broad authorities, which either cover certain LTSS as a benefit under the Medicaid state plan or cover home and community-based LTSS through a waiver program which permits states to waive certain Medicaid requirements to allow the provision of these services.[12] The following describes the Medicaid state plan authority and various waiver authorities that either require or permit states to cover LTSS. In addition, other Medicaid statutory provisions that offer states incentives to further enhance or expand their LTSS delivery systems are identified.

LTSS State Plan Coverage

The state plan is the contract between a state and the federal government which describes how that state administers its Medicaid program and provides assurance that the state will meet federal Medicaid requirements in order to receive matching federal funds for program activities. In general, the Medicaid state plan describes those groups of individuals to be covered, benefits to be provided, methodologies for providers to be reimbursed, and administrative requirements that states must meet to participate.[13] State plans are developed by the states and approved by the Centers for Medicare & Medicaid Services (CMS). States may update their state plans by submitting a state plan amendment (SPA) for CMS review and approval. Once a state plan or SPA is approved, states may receive matching federal funds for covered benefits without further need for CMS review or approval.

Medicaid statutory provisions require states to cover certain benefits under the "traditional" Medicaid state plan program (i.e., mandatory benefits) and give states the option to cover others (i.e., optional benefits). With respect to state plan benefits, federal law requires states to meet the following guidelines with some exceptions:

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information. Most states use a combination of functional and clinical criteria in defining the need for LTSS (L. Hendrickson and G. Kyzr-Sheeley, "Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment," Rutgers Center for State Health Policy, March 2008.)

[11] Effective March 17, 2014, CMS established requirements for home and community-based settings in Medicaid HCBS programs and aligns these requirements across three Medicaid authorities—Section 1915(c) HCBS waivers, Section 1915(i) HCBS state plan option, and Section 1915(k) Community First Choice (CFC) state plan option; Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," 79 *Federal Register* 2948-3039, January 16, 2014.

[12] As an alternative to states providing all of the mandatory and selected optional state plan benefits under "traditional" Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established benchmark and benchmark-equivalent coverage, now referred to as "alternative benefit plans" (ABPs). In general, these benefit packages look more like benefit coverage available in the private market and may cover fewer benefits than traditional Medicaid. However, in designing a Medicaid ABP, states may also choose to offer LTSS. Further discussion of LTSS offered in ABPs is beyond the scope of this report.

[13] CMS, *Medicaid State Plan Amendments*, at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html.

- Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity or functional level-of-care.
- Within a state, services available to certain groups of enrollees must be equal in amount, duration, and scope. This requirement is referred to as the "comparability" requirement.
- With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, also known as the "statewideness" requirement.
- With certain exceptions, beneficiaries must have "freedom of choice" among health care providers or managed care entities participating in Medicaid.

Waiver programs, on the other hand, allow states to provide benefits outside of some of these rules and to test new or existing ways to finance and deliver services. For example, waiver programs allow states to extend benefits that are, among other things, neither comparable across groups nor statewide. States must submit a separate waiver application for CMS review and subsequent approval. Unlike Medicaid state plan benefit coverage, Medicaid waiver benefit coverage is time limited for the duration of the waiver (e.g., three or five years) and must be renewed by the state subject to CMS approval. Together, these state plan and waiver authorities constitute a range of options that states have in designing their LTSS benefit packages for eligible beneficiaries.

Table 1 lists LTSS state plan benefits by the setting in which they are provided (institutional vs. HCBS) and whether they are a mandatory or optional state plan benefit.[14]

Table 1. Mandatory and Optional Medicaid State Plan Long-Term Services and Supports (LTSS)

	Mandatory Benefits	Optional Benefits
Institutional Services	Nursing Facility Services (age 21 and older) [SSA §1902(a)(10)(A) and §1905(a)(4)]	Nursing Facility Services (under age 21) [SSA §1905(a)(29)] Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID) [SSA §1905(a)(15)][a] Services in Institutions for Mental Diseases (IMDs) (age 65 and over) [SSA §1905(a)(14)] Inpatient Psychiatric Care (under age 21) [SSA §1905(a)(16)] Private Duty Nursing Services [SSA §1905(a)(8)]
Home & Community-Based Services	Home Health Services [SSA §1902(a)(10)(D) and §1905(a)(7]	Case Management/Targeted Case Management [SSA §1905(a)(19)] Personal Care Services [SSA §1905(a)(24)] Private Duty Nursing Services [SSA §1905(a)(8)] Rehabilitative Services [SSA §1905(a)(13)] State Plan Home and Community-Based Services [SSA §1915(i)] Self-Directed Personal Assistance Services [SSA §1915(j)] Community First Choice [SSA §1915(k)]

Source: CRS; for the full-range of Medicaid benefits, see the Centers for Medicare & Medicaid Services website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

a. Federal Medicaid law and regulations use the term "intermediate care facilities for the mentally retarded" and abbreviation "ICFs/MR"; however, federal agencies use the term individuals with "intellectual disability (ID)."

[14] With the exception of certain managed care or care coordination programs and services (e.g., PACE and health homes), this report includes Medicaid LTSS expenditures identified in Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

Mandatory State Plan Benefits

Among the Medicaid state plan LTSS benefits described below, the only benefits that participating states are required by federal law to cover are nursing facility services and home health. States must offer these services to eligible beneficiaries statewide. However, each state determines the amount, duration, and scope of these services. The following describes these LTSS benefits in greater detail.

Nursing Facility Services

States are required to cover nursing facility services for beneficiaries ages 21 and over under their Medicaid plans. States have the option to cover nursing facility services for beneficiaries under age 21. According to CMS, all states provide this optional service.[15] Beneficiaries must also meet state-defined nursing home eligibility criteria, referred to as level-of-care criteria. Nursing facility services include nursing care and related services, dietary services, physician services, specialized rehabilitation services (e.g., physical and occupational therapy, speech pathology and audiology services, and mental health rehabilitative services), emergency dental care, and pharmacy services.[16] Medicaid coverage of nursing facility services also includes room and board.

Home Health Services

Home health services are a mandatory benefit linked to requirements that states provide nursing facility care for certain individuals.[17] States must cover home health services for categorically eligible individuals *ages 21 and older* who are *entitled* to nursing facility coverage under a state's Medicaid state plan.[18,19] States must also offer home health to categorically eligible individuals *under age 21* if the state plan provides nursing facility services to this population group. Thus, home health services are a required benefit for beneficiaries *under* age 21 as well, as all states choose to cover nursing facility services for this population. Medicaid eligibility for the home health services benefit is not conditional on a need for institutional care or the need for skilled nursing or therapy services.

[15] CMS, "Nursing Facilities," at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html.

[16] 42 C.F.R. §483, subpart B.

[17] For more information, see U.S. Department of Health and Human Services, *Understanding Home and Community-Based Services: A Primer*, 2010, http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm.

[18] In general, there are two broad classifications of Medicaid eligibility groups: (1) categorically needy (which include both mandatory and optional eligibility groups) and (2) medically needy (optional eligibility group). Historically, Medicaid eligibility was subject to categorical restrictions that generally limited coverage to certain categories of individuals (i.e., "categorically needy") such as the elderly, persons with disabilities, or members of families with dependent children. States may choose to cover the "medically needy" who are individuals with income too high to qualify as categorically needy. Medically needy coverage is particularly important for the elderly and persons with disabilities, since this pathway allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid.

[19] Individuals who are entitled to nursing facility services are not necessarily eligible for such care. To be eligible for nursing facility services, entitled individuals must also meet state-based nursing facility eligibility criteria or level-of-care criteria. Federal regulations specify coverage groups entitled to home health as (a) categorically eligible individuals ages 21 or over; (b) categorically eligible individuals under age 21 if the state plan provides nursing facility services to this population group; and (c) medically needy individuals to whom nursing facility services are provided under the state plan (42 C.F.R. §441.15).

At a minimum the home health service benefit includes nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for in-home use.[20] States have the flexibility to offer additional therapeutic services under the home health benefit, such as physical therapy, occupational therapy, speech pathology, and audiology services. Once the home health benefit is determined, states must offer both the required and optional home health services to all Medicaid beneficiaries entitled to nursing facility services under their state plans. Home health services must be ordered by a physician as part of a written plan of care and reviewed by the physician every 60 days. States must provide home health services to beneficiaries in their place of residence with certain exceptions.[21]

Optional State Plan Benefits

States may cover other types of LTSS under a Medicaid state plan. These optional LTSS benefits assist older individuals and persons with disabilities who live in the community and may need assistance with activities of daily living. Medicaid coverage of these home and community-based services includes coverage of specific benefits such as case management or personal care. States also have authority to cover packages of HCBS benefits targeted at particular groups of beneficiaries. Similar to mandatory state plan benefits, each state determines the amount, duration, and scope of these services. The following describes these coverage options in greater detail. For state specific information about optional benefit coverage see **Appendix B**, **Table B-1**.

Case Management/Targeted Case Management

States may offer case management services to assist individuals who reside in community settings, or who are transitioning from an institutional to a community setting, in gaining access to needed medical, social, educational, and other services. Case management includes a comprehensive assessment and periodic reassessment of a beneficiary's needs, and development and implementation of a tailored care plan. Examples of case management services include service/support planning, monitoring of services, and assistance to beneficiaries with obtaining other non-Medicaid benefits, such as the Supplemental Nutrition Assistance Program (SNAP), energy assistance, and emergency housing.

States choosing to offer the case management benefit must make it available on a statewide basis. States also have the option to offer a targeted case management benefit to a specified beneficiary population within a specific geographic area. Like the case management benefit, states can use targeted case management to assist such individuals in gaining access to needed medical, social, educational, and other services. To be eligible for either benefit option, Medicaid beneficiaries must meet the state-defined eligibility criteria for that benefit. Forty-eight states and the District of Columbia (DC) offered optional targeted case management services in 2012.[22]

[20] See 42 C.F.R. §440.70.

[21] In 1997, Federal Court of Appeals for Second Circuit ruled that home health could be provided outside the home, as long as services do not exceed the hours of nursing care that would have been provided in the home. *Skubel v. Fuoroli*, 113 F. 3rd 330 (2d Cir. 1997).

[22] Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Targeted Case Management, 2012," at http://kff.org/medicaid/state-indicator/targeted-case-management/.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID)

States may provide services to eligible Medicaid beneficiaries residing in Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/ID) as an optional service under a state's Medicaid plan. The primary purpose of the ICF/ID is to furnish health and rehabilitative services to persons with intellectual disabilities or other related conditions.[23] ICFs/ID must provide certain services including nursing, physician, dental, pharmacy, and laboratory services.[24] According to CMS, beneficiaries who receive services in an ICF/ID are likely to have other disabilities or conditions in addition to intellectual disabilities, such as seizure disorders, behavior issues, and mental illness.[25] Medicaid specifies that the ICF/ID must provide a program of "active treatment," as defined by the Secretary of HHS. Federal regulations refer to "active treatment" as aggressive, consistent implementation of a program of generic and specialized training, treatment, and health services.[26] In 2012, 47 states and DC offered services in an ICF/ID.[27]

Services in Institutions for Mental Diseases (IMDs)

An Institution for Mental Disease (IMD) is defined as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[28] States may provide inpatient hospital and nursing facility services for eligible beneficiaries aged 65 and over with mental diseases that reside in IMDs under a state's Medicaid plan, also referred to as "IMD over 65." Mental diseases include any diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Edition 4, Text Revision (DSM-IV-TR), including those for substance use and addiction.[29] IMD services include diagnosis and medical treatment, as well as nursing care and related services under the direction of a physician. In 2012, 45 states and DC offered services in IMDs to individuals aged 65 and over.[30]

Inpatient Psychiatric Care

States may provide inpatient psychiatric care to eligible beneficiaries under age 21, often referred to as "Psych Under 21." Services may be provided in psychiatric hospitals, psychiatric units in

[23] Federal Medicaid law and regulations use the term "intermediate care facilities for the mentally retarded" and abbreviation "ICFs/MR"; however, federal agencies use the term individuals with "intellectual disability (ID)," which is the term and abbreviation used in this report.

[24] 42 C.F.R. §483.400, subpart I.

[25] CMS, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ICFMRs.html.

[26] 42 C.F.R. §483.440.

[27] Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities, 2012," at http://kff.org/medicaid/state-indicator/intermediate-care-facility-services-for-the-mentally-retarded/.

[28] 42 U.S.C. 1396d(i).

[29] Substance Abuse and Mental Health Services Administration. *Medicaid Handbook: Interface with Behavioral Health Services. HHS Publication* No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[30] Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older, 2012," at http://kff.org/medicaid/state-indicator/inpatient-hospital-nursing-facility-and-intermediate-care-facility-services-in-institutions-for-mental-diseases-age-65-and-older/.

general hospitals, and psychiatric residential treatment facilities (PRTFs), which provide comprehensive mental health treatment to children and young adults who, due to mental illness, substance abuse, or severe emotional disturbance, are in need of short-term mental health treatment. The goal of PRTF programs is to successfully return youth to the community. In 2012, all states and DC offered inpatient psychiatric care benefits to eligible beneficiaries under age 21.[31]

What Is the Medicaid Institution for Mental Diseases (IMD) Exclusion Rule?

Generally, states are responsible for the costs associated with services provided in an Institution for Mental Disease (IMD). The IMD exclusion rule prevents federal Medicaid funds from being used to care for individuals between 21 and 64 years of age who live in an IMD.

Two populations may receive Medicaid coverage for services received in an IMD. Thus, federal Medicaid matching payments are available for certain eligible beneficiaries in these settings. These populations are (1) adults age 65 and over; and (2) children under the age of 21 (in general). In the case of children, inpatient psychiatric care is a Medicaid state plan coverage option (described below), which is mandatory when a child's condition is diagnosed through an Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit screen.

The IMD exclusion applies to health providers that are IMDs with 17 beds or more that provide institutionalized services. Thus, health providers may receive federal Medicaid matching funds for partial hospitalization services and day treatment programs which do not require institutionalization. By definition, the IMD exclusion does not apply to settings with 16 or fewer beds, and federal Medicaid matching funds would be available to these providers.

Source: Substance Abuse and Mental Health Services Administration. *Medicaid Handbook: Interface with Behavioral Health Services.* HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. For further information, see CRS In Focus IF10222, *Medicaid's Institutions for Mental Disease (IMD) Exclusion*.

Personal Care Services

States may offer personal care services as an optional Medicaid state plan benefit. These services enable older individuals and persons with disabilities or chronic conditions to accomplish certain activities they would otherwise not be able to accomplish independently.[32] Personal care services include assistance with performing activities of daily living (ADLs) such as eating, bathing, dressing, toileting, and transferring (from a bed to a chair, etc.). Services may also include assistance with instrumental activities of daily living (IADLs), which facilitate independent living in the community, such as providing light housework, laundry, meal preparation, transportation, and grocery shopping. Assistance may be in the form of hands-on assistance (i.e., actually performing a task for an individual) or prompting an individual to perform the task by himself or herself. For individuals with cognitive impairments, such assistance may also include supervising or prompting an individual to perform the task.

States choosing to offer the personal care services benefit must make it available on a statewide basis. Personal care services must be authorized by a physician or, at state option, otherwise authorized under a state-approved plan of care. Services are furnished to individuals at home or, at state option, in other settings (such as a workplace or senior center). Services may not be provided to individuals who are inpatients or residents of hospitals, nursing facilities,

[31] Psych Under 21 refers to Inpatient psychiatric care to individuals under age 21; Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Inpatient Psychiatric Services, under age 21, 2012," at http://kff.org/medicaid/state-indicator/inpatient-psychiatric-services-under-age-21/.

[32] As per Section 1905(a)(24) of the SSA; 42 CFR 440.167; and Section 4480 of the State Medicaid Manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.

intermediate care facilities for individuals with intellectual disabilities (ICFs/ID), or psychiatric institutions. Personal care services must be provided by a qualified provider and may be furnished by family members, with the exception of legally liable relatives (i.e., spouses or parents of minor children). Furthermore, the provision of personal care services may be directed by the beneficiary, including the beneficiary having the ability to hire, train, and supervise personal care attendants.[33] In 2012, 30 states and DC covered personal care services.[34]

Private Duty Nursing Services

States may offer private duty nursing services to eligible beneficiaries who require greater individual and continuous care than what is available from a visiting nurse under a home health benefit or routinely provided by the nursing staff in an institutional setting.[35] Similar to skilled nursing, private duty nursing is more intensive and may cover situations where an individual's health care needs require extended care, including 24-hour-a-day coverage. For example, a beneficiary may be technology-dependent and rely on medical interventions such as mechanical ventilation, tube feedings, or intravenous medications. Skilled nursing services are provided by a registered nurse or a licensed practical nurse under the direction of the beneficiary's physician. At the option of the state, such services can be provided to a beneficiary in either an institutional setting such as a hospital or a skilled nursing facility or a community-based setting. In 2012, 22 states and DC covered private duty nursing services.[36]

Rehabilitative Services

States can offer a distinct rehabilitative services benefit as a state plan option that provides individuals with services related to the rehabilitation of physical or mental health conditions. The rehabilitative services option is broadly defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." States choosing to offer this benefit must offer it on a statewide basis.

The rehabilitative services option can be provided in community settings, including in an individual's home or work environment, and can be provided by professionals and paraprofessionals. There is no requirement that rehabilitative services be provided under a physician's direction. This benefit option is distinct from rehabilitative services offered in institutional settings such as a Medicaid nursing facility or ICF/ID. Services provided under the optional Medicaid rehabilitative benefit span a wide range of treatments from physical rehabilitation to behavioral health and substance abuse treatment. Often the rehabilitative services benefit option assists beneficiaries who have mental health conditions.[37] States may also utilize the rehabilitative services option to provide beneficiaries with physical, occupational, and speech

[33] Section 1915(j) of the SSA expands participant direction for personal care services for states offering such care under their Medicaid state plan or offering a 1915(c) HCBS waiver program. See section entitled "Self-Directed Personal Care Assistance" below.

[34] Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Personal Care Services, 2012," at http://kff.org/medicaid/state-indicator/personal-care-services/.

[35] 42 CFR §440.80.

[36] Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Private Duty Nursing Services, 2012," at http://kff.org/medicaid/state-indicator/private-duty-nursing-services/.

[37] Crowley, J.S., and M. O'Malley, *Policy Brief; Medicaid's Rehabilitation Services Option: Overview and Current Policy Issues*, Kaiser Commission on Medicaid and the Uninsured, August 2007.

therapy, as well as other comprehensive services to treat and help individuals recover from substance abuse disorders. In 2012, all states and DC covered rehabilitative services as an optional benefit.[38]

State Plan HCBS Option (Section 1915(i) of SSA)

Section 1915(i) of the SSA allows states to offer a broad range of HCBS under their Medicaid state plan. States that choose this optional benefit can cover HCBS for certain eligible Medicaid beneficiaries without obtaining a Secretary-approved waiver for this purpose. However, eligible beneficiaries must meet specific financial and needs-based eligibility criteria for the state plan HCBS Option. To be eligible for the Section 1915(i) benefit, Medicaid beneficiaries' incomes must be less than or equal to 150% of the federal poverty level (FPL, $1,508 per month for an individual in 2017).[39] In addition, they must have a level-of-care need that is less than the level of care required in an institution. States may extend eligibility for the Section 1915(i) benefit to beneficiaries with incomes up to 300% of the maximum Supplemental Security Income (SSI) benefit ($2,205 per month for an individual in 2017)[40] for those eligible for HCBS under home and community-based waiver programs.[41] For eligible beneficiaries who meet this higher financial eligibility threshold and waiver criteria, their level-of-care need may have to meet the level of care provided in an institution.[42]

The HCBS state plan option allows states to tailor different benefit packages to certain groups of beneficiaries. States can make this option available to specific populations and can vary the benefit package, as well as the amount, duration, or scope of the benefits for each of these populations. Such elections are for five-year periods (i.e., an initial five-year period and subsequent five-year renewal periods). States must offer benefit packages statewide and may not cap the number of beneficiaries receiving state plan HCBS. To help states manage enrollment, Medicaid law allows states to modify their needs-based criteria without obtaining prior approval from the HHS Secretary.

In the design of each benefit package, states may choose from the same list of services offered under a Section 1915(c) HCBS waiver program (see **Table 4** for a general description of these services). The list includes services such as case management, home-maker/home health aide, personal care, adult day health, habilitation, and respite care. For individuals with chronic mental illness states may provide day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Similar to Section 1915(c) waivers, states have the ability to name and define Section 1915(i) services, as well as identify and define other services, subject to HHS Secretary approval. This flexibility has led to state variation in naming conventions and service definitions across HCBS state plan and waiver services.

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[38] Rehabilitative services include rehabilitation services for mental health and substance abuse; Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Rehabilitation Services – Mental Health and Substance Abuse, 2012," at http://kff.org/medicaid/state-indicator/rehabilitation-services-mental-health-and-substance-abuse/.

[39] HHS, "Poverty Guidelines, HHS Poverty Guidelines for 2017," at https://aspe.hhs.gov/poverty-guidelines.

[40] SSA, "2017 Fact Sheet," at https://www.ssa.gov/news/press/factsheets/colafacts2017.pdf.

[41] Includes Medicaid waiver programs authorized under Section 1115 of the SSA or Sections 1915(c), (d) or (e) of the SSA.

[42] States may also create a new Section 1915(i) eligibility pathway into Medicaid to increase access to HCBS for individuals who need a lower level of care than is provided in an institution. States may extend full Medicaid benefits to this new eligibility group.

In addition, states may seek HHS Secretary approval to offer other services, with the exception of room and board. Section 1915(i) services must be provided in a home and community-based setting.[43] As of December 2015, 16 states and DC reported having a Section 1915(i) state plan HCBS option in place.[44]

Self-Directed Personal Care Assistance (Section 1915(j) of SSA)

Section 1915(j) of the SSA authorizes states to provide self-directed personal care assistance services (PAS), which include personal care and related home and community-based services. States can provide self-directed options either under a state's Medicaid State plan, if personal care is an existing state plan benefit option, and/or an existing Section 1915(c) HCBS waiver. Participation in self-directed PAS is voluntary and states may limit the number of individuals who self-direct. States are not required to provide self-directed PAS on a statewide basis and may target the benefit to particular geographic regions. States have the option to disburse cash prospectively to participants who direct their PAS. States also have the option to allow participants to hire legally liable relatives to provide care (such as spouses or parents) and purchase non-traditional goods and services that increase independence or substitute for human assistance other than personal care. An eligible participant's service plan is based on an assessment of need for PAS and developed with a person-centered and directed planning process. In FY2014, six states participated in the Section 1915(j) PAS state plan option.[45]

Community First Choice Option (Section 1915(k) of SSA)

Section 1915(k) of the SSA, the Community First Choice (CFC) Option, allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and receive an increased FMAP rate of 6 percentage points for doing so.[46] Eligible beneficiaries include those who are (1) eligible for medical assistance under the state plan and (2) in an eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet institutional level-of-care criteria to be eligible for CFC services.[47] States must provide these services on a statewide basis and in the most integrated community-based setting in which individuals with disabilities interact with non-disabled individuals.

Community-based attendant services and supports include attendant services and supports to assist eligible individuals in accomplishing ADLs, IADLs, and health-related tasks. Such services must be delivered under a person-centered plan of care in which attendants are selected, managed,

[43] See footnote 11.

[44] Kaiser Family Foundation, "State Health Facts, Section 1915(i) Home and Community-Based Services State Plan Option," Deccember 2015, at http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/.

[45] Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

[46] CMS issued a final rule on the CFC Option, see Department of Health and Human Services, "Medicaid Program; Community First Choice; Proposed Rule," 77 *Federal Register* 26362-26406, May 7, 2012. The rule did not finalize requirements regarding CFC settings, these requirements were finalized in a subsequent rule published January 16, 2015, see Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," *79 Federal Register* 2948-3039, January 16, 2014.

[47] Ibid., p. 26837.

and dismissed by the recipient (or his or her representative). Attendants must be qualified to deliver such services and may include family members (as defined by the HHS Secretary). This state plan benefit may also fund transition expenses when a beneficiary moves from a nursing facility to a community-based setting. Such expenses might include security deposits for an apartment or utilities, bedding, and basic kitchen supplies, among other expenses necessary to accomplish the transition. Additionally, states may provide services that increase independence or substitute for human assistance, such as non-medical transportation or purchasing a microwave oven.[48]

Additional requirements for states who offer the CFC optional benefit include (1) collaborating with a state-established Development and Implementation Council; (2) establishing and maintaining a comprehensive, continuous quality assurance system; and (3) collecting and reporting information for federal oversight and evaluation. In the first full fiscal year in which the state plan benefit is implemented, states must maintain or exceed the preceding fiscal year's Medicaid expenditures for individuals with disabilities or elderly individuals. As of January 2017, eight states have a CFC option in place. CMS is also providing technical assistance to additional states who are considering providing the CFC benefit.[49]

Table 2 shows Medicaid LTSS expenditures (both federal and state) for certain mandatory and optional state plan services for FY2014, which is the most recent year in which these data are available.

Table 2. Medicaid LTSS Expenditures for Selected Mandatory and Optional State Plan Services, FY2014

Service Type	Total Medicaid Payments ($ Billions)
Mandatory State Plan Services	
Nursing Facility Services	$55.2
Home Health Services	$4.6
Optional State Plan Services	
Personal Care Services	$14.4
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID)[a]	$10.4
Community First Choice §1915(k)	$4.4
Mental health facilities[b, c]	$2.7
Rehabilitative Services[b]	$3.3
Case Management[b]	$2.7
Private Duty Nursing[b]	$0.8
HCBS State Plan §1915(i)	$0.4
HCBS/Personal Care §1915(j)	$0.4

[48] Ibid., p. 26828.

[49] Centers for Medicare & Medicaid Services (CMS), Medicaid & CHIP, *Strengthening Coverage, Improving Health, January 2017*, p. 24, https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

Source: Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, based on data primarily identified in CMS-64 reports and represent total (federal and state) Medicaid payments. CMS-64 data are supplemented with managed care data collected directly from states that have managed LTSS programs.

Notes: For FY2014, Medicaid payment data do not include managed care programs in California, Massachusetts, and North Carolina. Data for several states include expenditures for Medicaid Upper Payment Limit (UPL) programs or provider taxes.

a. Federal Medicaid law and regulations use the term "intermediate care facilities for the mentally retarded" and abbreviation "ICFs/MR," however, federal agencies use the term individuals with "intellectual disability (ID)."

b. Data are for fee-for-service payments to mental health facilities, rehabilitative services, case management, and private duty nursing and do not include services provided through managed care organizations.

c. An additional $2.5 billion in disproportionate share hospital payments, not reflected in the payment data above, was provided to mental health facilities.

Home and Community Care for Functionally Disabled Elderly Individuals (Section 1929 of SSA)

Section 1929 of the SSA allows states to provide home and community care services for Medicaid beneficiaries, aged 65 or over, who are determined to be functionally disabled and are eligible for Medicaid coverage.[50] Eligible beneficiaries can only receive covered home and community care benefits and are not eligible for full Medicaid state plan benefits. Services must be furnished in accordance with an individual community care plan that is reviewed and revised by a qualified community care case manager. Under this authority, states may cover one or more of the following services: homemaker/home health aide services, chore services, personal care, nursing care, respite care, training for family members in managing the individual's care, and adult day care. For individuals with chronic mental illness, states may cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services. States may waive the "statewideness" requirement under this section. States may also cover other services approved by the HHS Secretary, with the exception of room and board. Federal matching payments to participating states may not exceed 50% of the aggregate amount that would have been spent to provide Medicare skilled nursing facility services to persons receiving home and community care. Federal matching payments can also be reduced if the state fails to maintain levels of certain nonfederal expenditures. Texas offers personal care services under Section 1929 and is the only state that uses this Medicaid statutory authority.[51]

Table 3 compares key features of selected options states have to provide HCBS under Medicaid. Section 1915(c) waivers are discussed in greater detail under the section entitled "Medicaid Waivers." These HCBS options are illustrative of the variation that exists within the Medicaid program for covering LTSS. Thus, while states may offer the same services, whether these services are offered as state plan or waiver services may determine whether all Medicaid beneficiaries have access to these services statewide or to a specific geographic area.

In addition, states that choose to offer HCBS under either the Section 1915(c) waiver or Section 1915(i) HCBS state plan authority have discretion in determining the HCBS benefit package,

[50] Generally, states are not permitted to apply the more liberal financial standards that states may use for persons served under Section 1915(c) waiver programs (i.e., 300 percent of the SSI benefit) unless they discontinue their wavier programs and provide coverage to such waiver participants under this new optional benefit.

[51] Sowers, M., H. Claypool, and M. Musumeci, *Streamlining Medicaid Home and Community-Based Services: Key Policy Questions*, Kaiser Family Foundation, March 2016, http://files.kff.org/attachment/issue-brief-streamlining-medicaid-home-and-community-based-services-key-policy-questions.

including the service type and definition. Thus, states may use different terms to refer to the same types of service, and similarly named services may be defined differently across waiver programs within a state as well as across states. For example, states may refer to personal care services as personal attendant services, personal assistance services, or attendant care services. This program-level variation makes it difficult to summarize and compare state Medicaid HCBS offerings both within a state and nationally.

Table 3. Key Features of Selected Coverage of HCBS Under Medicaid

Feature	Optional HCBS State Plan Benefits	§1915(c) HCBS Waiver	§1915(i) HCBS State Plan Benefits	§1915(k) Community First Choice State Plan Benefits
Benefit Eligibility	States must provide services to all categorically eligible individuals who are enrolled in Medicaid and meet the needs-based criteria	States can target services to specific populations (e.g., age and diagnosis) who meet the needs-based criteria, and can limit the number of people served	States can target services to specific populations (e.g., age and diagnosis), but must provide services to all individuals in an eligibility group who meet the applicable financial and needs-based criteria[a]	States must provide services to all individuals who are enrolled in Medicaid in an eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet the needs-based criteria
Geographic Criteria	Services must be available statewide	Services can be limited to certain geographic area(s)	Services must be available statewide	Services must be available statewide
Needs-Based Eligibility Criteria	Beneficiaries must have functional limitations that result in the need for covered services, as specified by the state	Beneficiaries must meet institutional level-of-care criteria	Beneficiaries must meet needs-based criteria that are less stringent than institutional level-of-care criteria Beneficiaries eligible for certain approved waiver programs with income that does not exceed 300% of the maximum SSI income eligibility standard may also have to meet institutional level-of-care criteria	Beneficiaries must meet institutional level-of-care criteria

Feature	Optional HCBS State Plan Benefits	§1915(c) HCBS Waiver	§1915(i) HCBS State Plan Benefits	§1915(k) Community First Choice State Plan Benefits
Coverable Services	Only federally specified services for each of the following: personal care, private duty nursing, case management, and rehabilitative services	A broad array of state-defined services, some of which are specified in federal statute, such as adult day health, case management, habilitation, homemaker, home health aide, personal care, respite care, and other Secretary approved services[b]	Same as Section 1915(c) HCBS waiver	Coverage includes personal care attendant services and supports and may include transition costs (e.g., first month's rent, utilities) and services that improve independence or substitute for human assistance, such as non-medical transportation services
Permits Payment of Relatives	Relatives who are not legally responsible may provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services under specific circumstances as determined by the state	Same as Section 1915(c) HCBS waiver	Same as Section 1915(c) HCBS waiver
FMAP Rate	Regular state FMAP rate	Regular state FMAP rate	Regular state FMAP rate	6% enhanced state FMAP rate[c]
Subject to Renewal	No	Yes, initial term of three years, renewable for five-year periods[d]	Yes, renewable every five years	No

Source: CRS analysis, adapted from HHS, *Understanding Medicaid Home and Community-Services: A Primer*, 2010, Table 4-2, pg. 110.

Notes: Personal care services are also referred to as personal attendant services, personal assistance services, or attendant care services. FMAP refers to the federal medical assistance percentage, which determines the federal share for most Medicaid service costs.

a. States may also create a new Section 1915(i) eligibility pathway into Medicaid to increase access to HCBS for individuals who need a lower level of care than is provided in an institution. States may extend full Medicaid benefits to this new eligibility group.

b. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

c. The Section 1915(k) CFC enhanced FMAP rate is the state's regular FMAP rate plus 6 percentage points.

d. Per January 16, 2014, final rule (*79 Federal Register* 2948-3039), states may request an initial period of five years if the waiver includes individuals who are dually eligible for Medicare and Medicaid.

Medicaid Waivers

Medicaid law also provides the HHS Secretary with authority to offer a broad range of home and community-based services (HCBS) to individuals with disabilities of all ages under Medicaid "waiver" programs. The term Medicaid "waiver" is so-named because states may request that the HHS Secretary waive certain statutory requirements that would normally apply to services covered under their Medicaid state plans. The most common waiver authority states use to provide HCBS to Medicaid beneficiaries is the Section 1915(c) waiver authority, named for the

section of Medicaid law in which it is authorized. Individuals served under Section 1915(c) waiver programs live in a community-based setting but require the level of care offered in an institution. Some states also use the waiver authority under SSA Section 1115, Research and Demonstration Projects, to cover HCBS. These waiver options are described in greater detail below.[52]

Section 1915(c) waivers, often referred to as HCBS waivers, are designed to expand opportunities for states to provide home and community-based care to additional groups of persons with LTSS needs while containing costs. Under this authority, states with approved applications may provide home and community-based care to persons who, without these services, would require Medicaid-covered institutional care. Section 1915(c) waivers permit states to cover services that go beyond the medical and medically related benefits that have been the principal focus of the Medicaid program. States can also cover a wide variety of nonmedical, social, and supportive services that allow individuals to live independently in the community.

The Medicaid statute specifies a broad range of services that states may provide to waiver participants. These services include case management, homemaker/home health aide, personal care, adult day health, habilitation, rehabilitation, and respite care. States also have flexibility to offer additional services when approved by the HHS Secretary. For the chronically mentally ill, Section 1915(c) authorizes states to cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Section 1915(c) waivers may *not* cover room and board in a community-based setting, such as an assisted living facility.

For a general description of the types of services covered under Section 1915(c) waivers, see **Table 4**. Note that states have the ability to name and define Section 1915(c) waiver services, as well as identify and define other services subject to HHS Secretary approval. Thus, there is tremendous state-to-state variation in naming conventions and service definitions across Section 1915(c) waiver programs.

Table 4. Covered Medicaid Services Under Section 1915(c) Home and Community-Based Services (HCBS) Waiver Programs

Service	General Service Description
Adult Day Health	Services furnished on a regularly scheduled basis for four or more hours per day, one or more days per week, in a non-institutional, community-based setting that encompasses both health and social services needed to ensure the optimal functioning of the individual.
Case management	Services that assist individuals in gaining access to needed waiver and other state plan benefits, as well as needed medical, social, educational, and other services, regardless of the funding source.

[52] Sections 1915(d) and (e) of the Social Security Act provide waiver authority for the provision of HCBS to elderly individuals and certain children, respectively. According to CMS, no state elects to provide services under these authorities and are not described in this report (Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," *79 Federal Register* 2948-3039, January 16, 2014, p. 2956, fn 4.

Service	General Service Description
Habilitation	Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary for individuals to reside successfully in home and community-based settings. May include the following types of habilitation: residential habilitation, day habilitation, certain prevocational services, certain educational services, and supportive employment services.
Homemaker	Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage such activities.
Home Health Aide[a]	Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved state plan or are provided when home health aide services furnished under the approved state plan limits are exhausted.
Personal Care[b]	Services to assist with activities of daily living (ADLs) such as eating, bathing, dressing, and personal hygiene. May include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores which are incidental to the care furnished, or which are essential to the health and welfare of the individual.
Respite Care	Services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care.
Other (Secretary approved)	Other specified services under the waiver program may include home modifications, skilled nursing services, non-medical transportation, specialized medical equipment and supplies, personal emergency response systems, adult foster care, and assisted living services, among others.

Source: Section 1915(c) HCBS Waiver Application Instructions, "Appendix C: Participant Services," at http://157.199.113.99/WMS/help/35/appInstrSecC.html. Covered services are those listed in Section 1915(c)(4)(B) of the SSA. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

a. Home health services are a mandatory state plan service. Home health aide services are a component of the state plan coverage. In a waiver, a state may elect to furnish home health aide services that are different in their scope and nature than the services offered under the state plan.

b. Personal care services are an optional benefit that a state may furnish under its state plan, as provided in 42 CFR §440.167. A state may offer personal care under a waiver when (a) it does not offer personal care under its state plan; (b) its coverage under the waiver differs in scope and nature from the coverage under the state plan; or (c) the state wishes to furnish personal care services in an amount, duration, or frequency that exceeds the limits in the state plan.

States must target a Section 1915(c) waiver to a specific population, such as individuals under age 65 with physical disabilities, individuals with intellectual or developmental disabilities, individuals ages 65 and older, or individuals with mental illness. As a result, states typically have more than one approved Section 1915(c) waiver, with each waiver program offering a specialized package of HCBS to a specific population. On January 16, 2014, CMS released a final rule that provides states the option to combine target groups within one waiver program.[53] Prior to this change, a Section 1915(c) waiver could only serve one of the following three target groups: (1) older adults, individuals with disabilities, or both; (2) individuals with intellectual disabilities,

[53] Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," *79 Federal Register* 2948-3039, January 16, 2014.

developmental disabilities, or both; or (3) individuals with mental illness. Whether states use this flexibility to combine waiver target groups into one waiver program, which may reduce the total number of waiver programs both across states and within a state, remains to be seen. Eligible waiver participants must meet certain financial requirements (including income and resource requirements) and state-defined level-of-care criteria that demonstrate the need for LTSS. That is, individuals must have a level of need for LTSS that would otherwise be covered under a Medicaid institutional benefit, such as nursing facility care, Intermediate Care Facility for the Individual with Intellectual Disabilities (ICF/ID), or hospital care.

Under Section 1915(c), the HHS Secretary has the authority to waive Medicaid's "statewideness" requirement to allow states to offer HCBS in a limited geographic area. The HHS Secretary may also waive the "comparability" requirement that services be comparable in amount, duration, or scope for individuals in particular eligibility categories. States may use the Section 1915(c) waiver to limit the number of individuals served by capping enrollment. The Section 1915(c) waiver is time limited and waiver approvals are subject to reporting and evaluation requirements. State-approved Section 1915(c) waivers must also meet a "cost-neutrality" test where average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. A majority of states with Section 1915(c) waivers (88%) use cost-containment strategies in addition to the federally mandated cost neutrality requirement, such as fixed expenditure caps either applied to individual participants or in aggregate as well as service limitations, and geographic limits.[54] Expenditures under these waivers are matched at the state's regular FMAP rate.

In 2013, more than 1.5 million Medicaid beneficiaries were receiving services under Section 1915(c) HCBS waivers.[55] At that time, 47 states and DC offered at least one Section 1915(c) HCBS waiver, with states generally offering multiple waivers targeting HCBS to different groups.[56] Nationwide, there were 289 Section 1915(c) HCBS waivers active in 2013.[57] For FY2014, Medicaid expenditures for Section 1915(c) HCBS waivers were $41.5 billion.[58] The majority of waivers target the aged and disabled populations (48%), followed by waivers for individuals with intellectual and developmental disabilities (I/DD, 41%), with the remaining 11% targeting other populations such as persons with physical disabilities, children with special health care needs, and individuals with traumatic brain injuries, HIV/AIDS, and mental health needs.[59]

[54] Terrance Ng, Charlene Harrington, MaryBeth Musumeci, et al., *Medicaid Home and Community-Based Services Programs: 2013 Data Update*, Kaiser Commission on Medicaid and the Uninsured (KCMU), October 18, 2016, p. 10, at http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/

[55] Ibid, p. 8.

[56] Arizona, Rhode Island, and Vermont do not offer Section 1915(c) HCBS waivers and instead operate their entire Medicaid LTSS programs under Section 1115 demonstration waiver authority.

[57] Terrance Ng, Charlene Harrington, MaryBeth Musumeci, et al., *Medicaid Home and Community-Based Services Programs: 2013 Data Update*, Kaiser Commission on Medicaid and the Uninsured (KCMU), October 18, 2016, p. 8, at http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update.

[58] Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

[59] Terrance Ng, Charlene Harrington, MaryBeth Musumeci, et al., *Medicaid Home and Community-Based Services Programs: 2013 Data Update*, Kaiser Commission on Medicaid and the Uninsured (KCMU), October 18, 2016, p. 8, at http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

Section 1115 Research and Demonstration Projects

Section 1115 provides the HHS Secretary with broad authority to waive certain statutory requirements, thus allowing states to conduct research and demonstration projects under several programs authorized by the SSA, including Medicaid. Under Section 1115, the HHS Secretary may waive Medicaid requirements contained in Section 1902 of the SSA including, but not limited to, "freedom of choice" of provider, "comparability" of services, and "statewideness." The HHS Secretary may also use Section 1115 waiver authority to provide federal funds for costs that are not otherwise matched under Section 1903 of the SSA.[60] States must submit proposals outlining terms and conditions for proposed waivers to CMS and receive approval before implementing these programs.

Expenditures under approved Section 1115 waivers are financed through federal and state matching funds at the regular FMAP rate. However, unlike traditional Medicaid, costs associated with Section 1115 waiver programs must be "budget neutral" to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program. For example, costs associated with an expanded population (e.g., those not otherwise eligible under Medicaid), must be offset by spending reductions elsewhere within the Medicaid program. Several methods are used by states to generate cost savings for such waivers such as (1) limiting benefit packages for certain eligibility groups; (2) providing targeted services to certain individuals so as to divert them from full Medicaid coverage; and (3) using enrollment caps and beneficiary cost-sharing to reduce the amounts states must pay. Section 1115 waivers are time limited and approvals are subject to reporting and evaluation requirements.[61]

Some states use Section 1115 waivers, either in addition to or in lieu of Section 1915(c) HCBS waivers, to provide HCBS to targeted populations. Compared to Section 1915(c) HCBS waivers, the use of Section 1115 waivers offers states some additional flexibilities in the design of the HCBS benefit package, the organization of payments for services, and/or the delivery of care. For example, some states have used Section 1115 waivers to provide HCBS services to beneficiaries under managed care. Other states have used such waivers to allow beneficiaries to self-direct their LTSS by providing them with an individual budget to directly purchase services and hire legally responsible family members (e.g., spouse or parent) to provide care. A state may obtain approval for these practices and a variety of other self-directed activities under a Section 1115 waiver, including (1) changing the Medicaid eligibility requirements (e.g., allowing an individual to have more income and still qualify for Medicaid); or (2) waiving the requirement that the state only pay those agencies, or practitioners, that have provider agreements with the state.

In 2013, three states (Arizona, Rhode Island, and Vermont) used Section 1115 waivers to administer statewide Medicaid programs that include HCBS instead of Section 1915(c) HCBS waivers. Five states (Delaware, Hawaii, New York, Tennessee, and Texas) use Section 1115 waivers for Medicaid managed care programs that include HCBS for certain populations and/or specific geographic areas in their states in 2013. These states also use Section 1915(c) HCBS

[60] SSA Section 1903 describes the conditions under which federal financial participation is available. SSA Section 1115(a)(2) stipulates that expenditures under a waiver are eligible for matching under Section 1903.

[61] SSA Section 1115 waiver projects are generally approved for a five-year period, however, states may seek up to a three-year extension for their existing waiver program. The approval process associated with each type of extension is defined in statute at Section 1115(e) and at Section 1115(f), respectively.

waivers for other home and community-based services.[62] For FY2014, Medicaid expenditures for HCBS authorized under managed care authorities, including Section 1115, were $5.9 billion.[63]

[62] Terrance Ng, Charlene Harrington, MaryBeth Musumeci, et al., *Medicaid Home and Community-Based Services Programs: 2013 Data Update*, Kaiser Commission on Medicaid and the Uninsured (KCMU), October 2016, p. 10, at http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2013-data-update/.

[63] Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

Appendix A. Legislative History of Medicaid Long-Term Services and Supports (LTSS)

Prior to the enactment of Medicaid in 1965, homes for the aged and other public institutions were financed by a combination of direct payments made by individuals from their Old Age Assistance benefits,[64] and vendor payments made by states with federal matching payments on behalf of individuals. The Kerr-Mills Medical Assistance to the Aged program enacted in 1960 (P.L. 86-778) allowed states to provide medical services, including skilled nursing care, to persons who were not eligible for Old Age Assistance cash payments, thereby expanding the covered population.

In 1965, when Kerr-Mills was incorporated into the new federal-state Medicaid program, Congress created an entitlement to skilled nursing facility care for beneficiaries age 21 and older, requiring all states to offer this service under the expanded program.[65] It also gave skilled nursing facility care the same priority status as hospital and physician services. Subsequent amendments allowed states to provide care in "intermediate care facilities" for persons who did not need skilled nursing facility care, but needed assistance beyond room and board alone.[66] In 1987, Congress eliminated the distinction between skilled nursing facilities and intermediate care facilities (effective in 1990) in the Medicaid program. Medicaid law now refers collectively to these facilities as nursing facilities.[67]

These early legislative developments helped stimulate growth in the nursing home industry. A significant increase in the number of nursing homes was seen from 1960 to 1970. Over that time period the number of nursing homes more than doubled, from around 9,600 to almost 23,000, and the number of beds more than tripled from 331,000 to more than 1 million.[68] Since 1970, the count of nursing homes nationwide has declined, but the number of beds has increased. For example, in 2014, the total number of nursing homes nationwide totaled 15,600 while the number of beds totaled about 1.7 million.[69]

Home care services also received some congressional attention in Medicaid's original authorizing statute. Under the 1965 law, home health care was established as one of the optional services that states could provide. In 1968, three years after Medicaid was established, Congress amended the law to require states to provide home health care to persons entitled to skilled nursing facility care as part of their state Medicaid plans (effective in 1970).[70] Over time, states were authorized to cover other types of home and community-based services (HCBS) as optional benefits under the

[64] Enacted in 1935 under Title I of the Social Security Act (P.L. 74-271), Old-Age Assistance was a federal-state program that provided payments to needy persons aged 65 or older. Congress replaced the Old-Age Assistance program, along with two other public assistance programs, with the federal Supplemental Security Income (SSI) program in 1972 (Herman F. Grundman, *Adult Assistance Programs Under the Social Security Act*, Social Security Bulletin, vol. 48, no. 10, October 1985).

[65] Social Security Amendments of 1965 (P.L. 89-97).

[66] Act of December 14, 1971 (P.L. 92-223).

[67] Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

[68] U.S. Congress, Senate Special Committee on Aging, *Developments in Aging, 1970*, Report 92-46, Feb. 16, 1970, Washington, p. 42, cited from the American Nursing Home Association Fact Book, 1969-1970.

[69] National Center for Health Statistics, *Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers, 2013–2014*, 2016, https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf.

[70] Social Security Amendments of 1967 (P.L. 90-248), effective July, 1970.

Medicaid state plan. For example, the optional personal care benefit was first available in 1978.[71] To enable states to make improvements in the management of care for their LTSS beneficiaries and other groups, Congress added an optional case management benefit in 1986.[72]

Medicaid Home and Community-Based Waivers

During the 1970s, the former Department of Health, Education and Welfare (HEW) devoted increased attention to alternatives to nursing home care through a variety of federal research and demonstration efforts.[73] These efforts were undertaken not only to find ways to offset the high cost of nursing facility care, but also to respond to the desires of persons with disabilities to remain in their homes and in community-based settings, rather than in institutions. However, it was not until 1981 that Congress took significant legislative action to expand HCBS when it authorized the Medicaid Section 1915(c) Home and Community-Based Waiver Program.[74]

Congress established the Section 1915(c) waiver program in response to general concerns about the lack of federal funding for home and community-based care. The waiver program was also intended to respond to specific concerns that Medicaid provided far greater support for nursing facility care than home and community-based care. Prior to 1981, many of the non-skilled personal care and supportive services needed by chronically impaired persons to remain in the community were not covered under Medicaid. With approved waiver programs, states were authorized to cover a wide variety of nonmedical, social, and supportive services designed to assist individuals with independent living.

The Olmstead Decision

In 1999, the U.S. Supreme Court ruled on a landmark case for individuals with disabilities, *Olmstead v. L.C.*[75] The Court held that institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA).[76] This case prompted federal administrative and legislative activities to encourage efforts to provide expanded HCBS to persons with disabilities. Since this time, every state has taken up either the Section 1915(c) HCBS waiver program option or a comparable waiver under the authority of Section 1115 of the SSA, to offer HCBS to certain LTSS beneficiaries. To assist states in Medicaid LTSS delivery system transformation toward HCBS, in FY2001 Congress first appropriated funding for the Real Choice Systems Change Grants for Community Living

[71] Provided in federal regulation (43 *Federal Register* 45228, September 29, 1978). Congress then added personal care to the list of services specified in the Medicaid statute under the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66).

[72] Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272), effective April, 1986.

[73] U.S. General Accounting Office, *Home Health Care Benefit Under Medicare and Medicaid*, July 9, 1974, http://archive.gao.gov/f0302/094820.pdf.

[74] Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

[75] 527 U.S. 581 (1999).

[76] Specifically, the Court held that the Americans with Disabilities Act (ADA) requires states to transfer individuals with mental disabilities from institutions to less confining community settings when a state treatment professional has determined the latter is appropriate, the community setting is not opposed by the individual with a disability, and the placement can be reasonably accommodated by the state. A January 2000 Health Care Financing Administration (now Centers for Medicare & Medicaid Services) notice to state Medicaid directors indicated that the decision was applicable to all individuals with disabilities, not just those with mental disabilities.

Program. CMS awarded over 350 grants to states between FY2001 and FY2010 for a total of approximately $288.6 million.[77]

The Deficit Reduction Act

Under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), Congress established two optional state plan Medicaid benefits that allow states to cover certain HCBS for eligible beneficiaries.[78] One option gives states the authority to cover a new waiver-like HCBS state plan option (i.e., Section 1915(i) of the SSA) without requiring a Secretary-approved waiver for this purpose. Under this option, states may offer selected benefit packages to targeted populations so as to delay and/or prevent the need for institutional care. The second state plan option, under Section 1915(j) of the SSA, provides states the authority to offer consumer-directed personal care services with features such as individual budgets and the ability to purchase non-traditional goods and services. Among other things, these options incorporated certain elements that had previously only been allowed under Medicaid waivers, giving states greater flexibility to offer HCBS while targeting benefits to certain populations which may assist states in controlling related spending. The DRA also established the Money Follows the Person (MFP) Program, a demonstration grant program to provide assistance to eligible Medicaid beneficiaries who want to move from institutional settings—such as nursing homes—back to their homes or other community residential settings.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided a number of new options under Medicaid for states to further efforts to increase coverage of HCBS. First, the ACA added the Community First Choice (CFC) Option, a new authority under Section 1915(k) of the SSA, which authorizes states to offer personal care attendant services, among other services. States that choose this option will receive an increased FMAP rate of 6 percentage points. The ACA also expanded the Section 1915(i) HCBS state plan option established under the DRA. Among other changes, the ACA increased the amount of income individuals may have to qualify for the benefit and added new flexibility for states to target different benefit packages to specific populations with LTSS needs. In addition, ACA expanded the list of services states may cover to include state-selected services, other than room and board, that are approved by the HHS Secretary, which is similar to Section 1915(c) HCBS waiver programs. The ACA also granted states the option to establish a new Medicaid eligibility pathway for certain qualifying beneficiaries who meet the Section 1915(i) benefit's financial and needs-based criteria. Finally, the ACA established a four-year incentive payment program, referred to as the Balancing Incentive Payments (BIP) Program, and extended the Money Follows the Person (MFP) demonstration through 2016 by providing additional funding to support the original state grantees and to award grants to additional states.

[77] CMS, *Real Choice Systems Change Grant Program*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Real-Choice-Systems-Change-Grant-Program-RCSC/Real-Choice-Systems-Change-Grant-Program-RCSC.html.

[78] In addition, the DRA established new grants to help expand adult day care services into rural areas under the Program for All-Inclusive Care for the Elderly (PACE), an integrated Medicaid and Medicare program, and authorized additional grant funding to states to conduct demonstration projects to increase the use of and expand states' capacity to provide HCBS.

Appendix B. State Tables

Table B-1. Optional State Plan Medicaid Long-Term Services and Services (LTSS) Benefits, by State

State	Case Mngmt.[a]	ICF/ ID[b]	IMD 65+[c]	Psych. Under 21[d]	Pers. Care[e]	Priv. Duty Nurs.[f]	Rehab.[g]	HCBS §1915(i)[h]	PAS §1915(j)[i]	CFC §1915(k)[j]
(Year)	(2012)	(2012)	(2012)	(2012)	(2012)	(2012)	(2012)	(2015)	(2014)	(2017)
Alabama	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Alaska	Yes	Yes	Yes	Yes	Yes	—	Yes	—	—	—
Arizona	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Arkansas	Yes	Yes	—	Yes	Yes	Yes	Yes	—	Yes	
California	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes	—	—
Connecticut	Yes	Yes	Yes	Yes	—	—	Yes	Yes	—	Yes
Delaware	—	Yes	Yes	Yes	—	Yes	Yes	Yes	—	—
Dist. of Columbia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—
Florida	Yes	Yes	Yes	Yes	—	—	Yes	—	Yes	—
Georgia	Yes	Yes	—	Yes	—	—	Yes	—	—	—
Hawaii	Yes	Yes	—	Yes	—	—	Yes	—	—	—
Idaho	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	—	—
Illinois	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Indiana	—	Yes	Yes	Yes	—	Yes	Yes	Yes	—	—
Iowa	Yes	Yes	Yes	Yes	—	—	Yes	Yes	—	—
Kansas	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Kentucky	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Louisiana	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	—	—
Maine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Maryland	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	—	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Michigan	Yes	—	Yes	Yes	Yes	—	Yes	Yes	—	—
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Mississippi	Yes	Yes	—	Yes	—	—	Yes	Yes	—	—
Missouri	Yes	Yes	Yes	Yes	Yes	—	Yes	—	—	—
Montana	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	—	Yes
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—
New Hampshire	Yes	—	Yes	Yes	Yes	Yes	Yes	—	—	—
New Jersey	Yes	Yes	Yes	Yes	Yes	—	Yes	—	Yes	—
New Mexico	Yes	Yes	Yes	Yes	Yes	—	Yes	—	—	—

State	Case Mngmt.[a]	ICF/ ID[b]	IMD 65+[c]	Psych. Under 21[d]	Pers. Care[e]	Priv. Duty Nurs.[f]	Rehab.[g]	HCBS §1915(i)[h]	PAS §1915(j)[i]	CFC §1915(k)[j]
(Year)	(2012)	(2012)	(2012)	(2012)	(2012)	(2012)	(2012)	(2015)	(2014)	(2017)
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	Yes
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Ohio	Yes	Yes	Yes	Yes	—	Yes	Yes	—	—	—
Oklahoma	Yes	Yes	Yes	Yes	Yes	—	Yes	—	—	—
Oregon	Yes	—	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Rhode Island	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
South Carolina	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
South Dakota	Yes	Yes	Yes	Yes	Yes	—	Yes	—	—	—
Tennessee	Yes	Yes	Yes	Yes	—	Yes	Yes	—	—	—
Texas	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	—
Vermont	Yes	Yes	Yes	Yes	—	Yes	Yes	—	—	—
Virginia	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
Washington	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—	Yes
West Virginia	Yes	Yes	—	Yes	Yes	—	Yes	—	—	—
Wisconsin	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—	—
Wyoming	Yes	Yes	Yes	Yes	—	—	Yes	—	—	—
TOTAL	**49**	**48**	**46**	**51**	**31**	**23**	**51**	**17**	**6**	**8**

Source: CRS analysis of data for states and the District of Columbia from CMS, Kaiser Family Foundation: State Health Facts, and other published sources; data year indicated in parentheses.

Notes: Medicaid LTSS benefit coverage varies across states in the amount, duration, and scope of the benefit as well as the included services within a specific benefit (e.g., Section 1915(j) Personal Assistance Services).

a. Case Mngmt. refers to targeted case management. Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Targeted Case Management, 2012," at http://kff.org/medicaid/state-indicator/targeted-case-management/.

b. ICF/ID refers to Intermediate Care Facilities for Individuals with Intellectual Disabilities. Federal Medicaid law and regulations use the term "intermediate care facilities for the mentally retarded" and abbreviation "ICFs/MR"; however, federal agencies use the term individuals with "intellectual disability (ID)." Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities, 2012," at http://kff.org/medicaid/state-indicator/intermediate-care-facility-services-for-the-mentally-retarded/.

c. IMD 65+ refers to Institutions for Mental Diseases for individuals ages 65 and older; Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older, 2012," at http://kff.org/medicaid/state-indicator/inpatient-hospital-nursing-facility-and-intermediate-care-facility-services-in-institutions-for-mental-diseases-age-65-and-older/.

d. Psych Under 21 refers to inpatient psychiatric care to individuals under age 21; Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Inpatient Psychiatric Services, under age 21, 2012," at http://kff.org/medicaid/state-indicator/inpatient-psychiatric-services-under-age-21/.

e. Pers. Care refers to personal care. Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Personal Care Services, 2012," at http://kff.org/medicaid/state-indicator/personal-care-services/#.

f. Priv. Duty Nurs. refers to Private Duty Nursing. Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Private Duty Nursing Services, 2012," at http://kff.org/medicaid/state-indicator/private-duty-nursing-services/.

g. Rehab. refers to rehabilitative services include rehabilitation services for mental health and substance abuse; Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Rehabilitation Services – Mental Health and Substance Abuse, 2012," at http://kff.org/medicaid/state-indicator/rehabilitation-services-mental-health-and-substance-abuse/.

h. HCBS §1915(i) refers to the Home and Community-Based Services state plan option under the Section 1915(i) of the SSA; Kaiser Family Foundation, "State Health Facts, Section 1915(i) Home and Community-Based Services State Plan Option," December 2015, at http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/.

i. PAS §1915(j) refers to the Personal Assistance Services state plan option under Section 1915(j) if the SSA. States reporting expenditures for either Section 1915(j) personal care and/or Section 1915(j) HCBS in FY2014. Eiken, S., K. Sredl, B. Burwell, et al., *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014*, Truven Health Analytics, April 15, 2016, p Tables U and V at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

j. CFC §1915(k) refers to the Community First Choice state plan option under Section 1915(k) of the SSA; Centers for Medicare & Medicaid Services (CMS), *Medicaid & CHIP, Strengthening Coverage, Improving Health*, January 2017, p. 24, https://www.medicaid.gov/medicaid/program-information/downloads/accomplishments-report.pdf.

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