State Perspectives on Emerging Medicaid Long-Term Care Policies and Practices

NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS
AN AFFILIATE OF THE AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION
State Perspectives on Emerging Medicaid Long-Term Care Policies and Practices
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Acknowledgements

This survey represents an addition to a series of projects by the National Association of State Medicaid Directors (NASMD). This Long-Term Care survey, the second in our collection, provides us with a better understanding of Long-Term Care initiatives at the state and federal levels.

We would like to thank the more than 50 state officials who completed this comprehensive survey and responded to our follow-up questions. We recognize that this survey required a great deal of coordination among state Medicaid agencies and we appreciate all of the effort. We are extremely grateful to the members of the NASMD and Centers for Medicare and Medicaid Services Eligibility and Long-Term Care Technical Advisory Groups (TAG) for assisting us in the development of the survey instrument and in gathering the results. Chronic Care and Eligibility TAG member guidance was invaluable in the development of the publication.

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With appreciation,

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Executive Summary

Over the last decade, there has been a significant shift in distributing Medicaid Long-Term Care (LTC) funding towards home- and community-based services (HCBS) and away from institutional settings. During this time, states have increased their support for Long-Term Care services in individuals’ homes and in other community-based settings such as adult day care and assisted living facilities as an alternative to nursing homes and other institutions. For many vulnerable elderly and nonelderly individuals with physical, developmental, or cognitive disabilities, these alternative settings and services are seen as preferable to institutional care. The process for realigning policies to facilitate reform in the Long-Term Care systems and to foster the full integration of individuals with disabilities into society is complex and far-reaching. Since the elderly and persons with disabilities have significant health needs, they are among the most costly of Medicaid beneficiaries. Many government agencies and programs will need to enter into extensive assessments and interactive policy initiatives to remove the existing barriers woven through the fabric of federal and state policies.

The Deficit Reduction Act of 2005 (DRA) made significant changes in the Medicaid program, including changes in the states’ flexibility to design benefit packages, prescription drug payment policies, premium and cost-sharing rules, and Long-Term Care reforms. The purpose of this survey analysis is to provide the states with an overview of the implementation of these DRA changes across the country. This paper specifically reviews the DRA changes in Long-Term Care services and the steps the states have taken with respect to the changes. The following states and territories participated in the survey: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oregon, Ohio, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Please note that Guam and Puerto Rico have unique programs and therefore may not have answered some of the questions. In addition, the information on the Long-Term Care Partnership Programs (LTCPP) was taken from earlier work that was done in collaboration with George Mason University and the Center for Health Care Strategies.
The key findings of the survey include:

**Finding 1** Eligibility for Medicaid was Tightened Under the DRA and States Responded

**Finding 2** Most States Have not Used the Family Opportunity Act to Extend Medicaid Coverage to Children with Disabilities in Families with Higher Incomes

**Finding 3** States use their Money Follows the Person Grant Dollars in Several Ways

**Finding 4** To Date, Most States are not Opting to Switch to the New HCBS State Plan Amendment (SPA) Option

**Finding 5** States are Initiating Efforts to Transition Individuals Out of Institutions

**Finding 6** States are Using Managed Care for Individuals with Disabilities

**Finding 7** Fewer than 10 States Plan to Submit a SPA for Personal Care Services (Cash and Counseling) Programs

**Finding 8** Special Needs Plans are in Place in at Least 20 States, but States Have Concerns About Coordination Between Medicare and Medicaid

**Finding 9** Long-Term Care Reform in the States Continues to Encourage Home- and Community-Based Living

**Finding 10** States are Using Care Coordination to Improve and Integrate Care

**Finding 11** More States Using Disease Management to Help Manage Chronic Conditions

**Finding 12** Many States are Using the New Option on Long-Term Care Partnership Programs

**Finding 13** Benchmark Benefit Packages are not Widely used for Long-Term Care Services
The Deficit Reduction Act and Medicaid Long-Term Care Services

The Deficit Reduction Act made several major changes to how states can provide Long-Term Care services and who is eligible for those services. Specific changes included:

**Eligibility**
- Lengthens the look-back period on asset transfers.
- Changes the penalty period.
- Requires annuities to be disclosed and states named remainder beneficiary.
- Requires states to use the income-first rule.
- Excludes coverage for individuals with higher home equity.

**Long-Term Care Partnership Programs**
- Allows states to expand the Long-Term Care Partnership Programs.

**Family Opportunity Act**
- Creates a new option for states to extend Medicaid “buy-in” coverage to children with disabilities whose family income is up to 300 percent of poverty.

**Money Follows the Person Demonstration Program**
- Awards competitive grants to states to increase the use of HCBS.

**State Option to Provide HCBS Services**
- Allows states to provide a comprehensive package of community-based services under their Medicaid state plans that previously could only be provided by a waiver.

**Personal Care Services “Cash and Counseling” Option**
- Allows states to provide for self-direction of services without requesting a waiver.
Snapshot of the Medicaid Program
Long-Term Care Benefits

Medicaid Demographics
There are approximately 58 million Medicaid beneficiaries which constitutes approximately 20 percent of the total population of the U.S. The demographic breakdown of the Medicaid population is as follows:
- 52 percent are children age 17 and under.
- 23 percent are adults between the ages of 18 and 64.
- 15 percent are blind or disabled individuals under age 64.
- 10 percent are over the age of 65.

Medicaid Spending on Long-Term Care
- Medicaid accounts for at least 40 percent of all Long-Term Care services, making it the nation’s largest single payer of Long-Term Care services.1
- Total Medicaid Long-Term Care expenditures in FY 2006 equaled $99.3 billion, an increase of 3.4 percent over FY 2005.2
- Medicaid nursing home expenditures in FY 2006 were $47.7 billion.3
- Over 400,000 children and over 1 million adults under 65 use Long-Term Care services, and 75 percent of the children who use Long-Term Care services qualify for Medicaid.4

Medicaid Spending on Long-Term Care by Services
- 44 percent of Long-Term Care spending was on nursing facilities.
- 41 percent of Long-Term Care spending was home health and personal care services.
- 11 percent of Long-Term Care spending was on Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) services.
- 4 percent of Long-Term Care spending was on mental health facilities.5

Medicaid and Home- and Community-Based Services
- Individuals under 65 are more likely then those over 65 to use HCBS.6
- Expenditures for community-based Long-Term Care services continue to increase more rapidly than institutional expenditures.
- Total HCBS increased by 8.1 percent to $39.1 billion. HCBS waiver expenditures increased 10.6 percent to $25.6 billion and now account for about 65 percent of all Medicaid community-based Long-Term Care spending.7
- Spending for community-based Long-Term Care services rose to 39 percent of all Medicaid Long-Term Care costs, while 61 percent was spent on institutional services.8

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1 Kaiser Family Foundation: Medicaid/SCHIP: Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns, 2006 http://www.kff.org/medicaid/7576.cfm
3 Ibid.
4 Kaiser Family Foundation: Medicaid/SCHIP: Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns, 2006 http://www.kff.org/medicaid/7576.cfm
5 Ibid.
6 Kaiser Family Foundation: Medicaid/SCHIP: Medicaid’s Long-Term Care Beneficiaries: An Analysis of Spending Patterns, 2006 http://www.kff.org/medicaid/7576.cfm
8 Ibid.
Finding 1—Eligibility for Medicaid was Tightened Under the DRA and States Responded

The Deficit Reduction Act of 2005 (P.L. 109-171) created new Medicaid transfer-of-asset rules. On July 27, 2006, the Centers for Medicare and Medicaid Services (CMS) sent guidance to the states on how to implement the new requirements.9 To comply with tightening of eligibility under the DRA, the majority of states had to change their state laws. This section of the report deals with the specific provisions contained in Sections 6011 and 6016 of the Deficit Reduction Act and how states have responded.

Changing the Look-Back Period
Section 6011 of the DRA lengthened the look-back period for Medicaid eligibility from three to five years for all asset transfers, and 33 states have already made the necessary changes to comply with this new requirement. Of those states that have not yet made the changes, two states expect to make the changes in 2007, one state expects to make changes in 2010, two states are waiting for approval of a proposed rule, one state will be phasing the look-back period in, and one state does not need to make changes to comply at this time.

Changing the Start Date of the Penalty Period
Section 6011 also requires states to change the start date of the penalty period, and 34 states have already done so. Prior to the change in the law, the penalty period began either in the month of the transfer or in the month following the transfer. Some state and federal officials believed that some individuals were avoiding the penalty period by not applying for Medicaid services until the expiration of the penalty period, and therefore pressed for the statutory fix.

For those states that have already made the changes, the penalty period will begin in the month during which assets were transferred; in six states it will begin in the month after which assets were transferred and in 15 states it will begin on the first day of the month following advance notice.

For the states that have not yet implemented, two states are waiting for approval of a proposed rule, one state will implement in 2007, one state will implement by 2010, and one state will implement within three months after their state changes are enacted.

Changing the Requirements on Partial Months of Ineligibility
Prior to the DRA, states had the option to impose penalty periods for asset transfers in a month that were less than the state’s average monthly cost to a private patient of nursing home care in the state. Under the change in statute, states are now required to impose penalty periods even in the case of smaller asset transfers where the period of ineligibility would be less than a full month. If the calculation of the penalty period produces a fractional amount, the penalty must include a partial month disqualification.

In compliance with DRA Section 6016, 26 states have made the necessary changes to apply partial months of ineligibility for individuals applying for Medicaid assistance for their Long-Term Care costs; six states and Puerto Rico have not done so yet, one state is awaiting approval, and seven states indicated that changes are not needed because their current rules adequately address this issue. (Figure 1)

Samples of how states plan to calculate the penalty period for applicants not eligible on the first day of the month

- The penalty period shall be calculated by taking the total cumulative uncompensated value of the assets transferred, whether it is overlapping or not, on or after the look-back date and dividing this total by the current nursing home rate (at the time of application) as determined by Medicaid. The number of times this total can evenly be divided by the average monthly current nursing home rate shall be the number of months the uncompensated value is counted. The fractional remainder, converted to a dollar figure, shall be added to the individual’s liability amount in the month following the last month of the full month.
penalty period. (A penalty period will never be started in a month in which an applicant is ineligible.)

- The penalty period will begin with the date of transfer or the application month, whichever is the later date.
- If there is a penalty period, the individual will be eligible for restricted services.

- Divide the uncompensated value of the transferred asset by the average monthly nursing home cost. The result is a percentage (e.g., 50 percent). Determine the number of days there are in the month the penalty ends. The number of days’ penalty in that month is based on the percentage. For example, if the penalty ends in June, which has 30 days, and the percentage is 50 percent, then there are 15 days of penalty.
The penalty period is calculated on a daily basis. For those who do not meet the level of care until a day other than the first, an ineligibility period will be calculated in days, and they serve that period.

The penalty period calculation is the same regardless of whether the applicant is eligible or not eligible on the first day of the month. The calculation establishes the length of the penalty period. The state has the flexibility to begin the period and end the period any day of the month.

**Changes to Accumulate Multiple Transfers in One Month**

By the summer of 2007, at least 30 states will have made the changes to accumulate multiple transfers in more than one month and impose a single period of ineligibility into one penalty period in order to conform with DRA Section 6016. Four states and Puerto Rico have not done so yet, or are in the process of getting approval and six states do not need to do so because their current rules comply. Four states plan to implement in the summer of 2007, one state plans to implement by 2010, and two states are waiting for approval of a proposed rule. (Figure 2)
Changes Regarding Purchase of Promissory Notes, Loans, and Mortgages

By the fall of 2007 at least 35 states will have made the changes or do not need to make changes regarding purchase of promissory notes, loans, and mortgages that were outlined in Section 6016. (Figure 3)

Changing Requirements Regarding the Purchase of Life Estates

At least 32 states have made changes pertaining to Section 6016 regarding the purchase of life estates that require the individual purchasing the life estate in another’s home to reside there for a period of at least one year after the date of purchase. Four states and Puerto Rico have not implemented this yet. Of those states, one state will do so in 2010 and two states are waiting for approval of a proposed rule. Four states said that changes to their laws are not needed to comply. (Figure 4)
Changing the Hardship Waiver Provisions

Twenty-eight states have made the changes that deal with the availability of hardship waivers, five states and Puerto Rico have not yet done so, and six states do not need to do so because their current laws comply. Of the states that have made changes, several indicated that they made additional changes to their existing hardship waiver policy including clarifying the notice requirement, expanding the definition of hardship, and adding a home equity evaluation as a hardship request.

Examples of how states will determine the granting of hardship waiver requests and exceptions

- The agency may grant exemption from the penalty period if the individual demonstrates with clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. All undue hardships are reviewed by the state Deputy General Counsel.
In cases where there has been financial exploitation by a family member or other third party and there is no evidence that the recipient participated in the transfers and the transferred assets cannot be returned, then a hardship waiver will be granted.

The person receives an eviction notice from the nursing home and has tried all legal means to stop the eviction.

The individual is exploited as determined by the Adult Protective Unit, if the individual can prove all of the following: (1) neither the individual nor the spouse (taking into consideration all exempt and non-exempt income and assets) have the means to pay; (2) the recipient of the transferred asset is unable or unwilling to give the asset or any part of the asset back; (3) the individual has made all reasonable efforts to recover the transferred asset and cooperated with the department to recover the asset; (4) the individual must agree in writing that if the transferred asset or its equivalent is recovered, the individual will reimburse the state for funds expended as a result of the approved claim of undue hardship; and (5) that to prove it would be undue hardship.

The eligibility worker must obtain verification that a denial of benefits would result in a life-threatening situation, and it must be demonstrated that all other possible exceptions to the imposition of the transfer penalty have been explored.

Any of the following exist: (1) location of the receiver of the asset is unknown to the client or other family members or other interested parties, and the client has no place to return in the community and/or receive the care required to meet the client’s needs; (2) client can show that physical harm may come as a result of pursuing the return of the asset, and the client has no place to return in the community and/or receive the care required to meet the client’s needs; or (3) receiver of the asset is unwilling to cooperate (such as an Adult Protective Services exploitation or potential fraud case) with the client, and the client has no place to return to in the community and/or receive the care required to meet the client’s needs.

The person to whom the asset(s) was transferred has no reasonable way to make arrangements for the person seeking care up to the value of the transfer; and the person seeking care has made reasonable efforts to obtain return of the asset(s); and the person seeking care can demonstrate that efforts to obtain the asset(s) or adequate value for them probably would not succeed.

The client is unable to access home equity in excess of $500,000 due to a lien or legal impediment, and without these services the client will be endangered.
Changes in Annuities Relating to the Disclosure of Interests and Remainder Beneficiary

Thirty-one states have made the changes as a result of DRA Section 6012 that deal with the changes in annuities requiring the applicant to disclose his/her interest or his/her spouse’s interest in an annuity and name the state as remainder beneficiary.

Income-First Rule Changes

Thirteen states have made changes with regard to the income-first rule, three states and Puerto Rico have not made changes, and 24 states do not need to make changes because their current rules comply with this requirement. One state is waiting for approval of a proposed rule before implementing, one state will implement shortly, and one state is still unsure about when they will be able to implement.

Changes in Home Equity Limits

Section 6014 allows states to set the home equity limit higher than $500,000, but only seven states plan to set the limit higher than $500,000. As many as 33 states and Puerto Rico do not plan to set their home equity limit higher than $500,000. For the seven states that are going to have a higher home equity limit, all plan to set their home equity limit at $750,000 and apply the higher limit statewide. Most states who plan to have a higher home equity limit plan to apply this to all eligibility groups, but one state plans to apply this to only those in institutions. One state plans to implement in the summer of 2007, one state plans to implement in 2010, and one state will implement within three months of the changes being enacted. (Figure 5)
Recalculating the Penalty Period

Twenty-eight states plan to recalculate the penalty period when a portion of the transferred resources are returned to the Long-Term Care recipient, and five states will require all of the transferred resources to be returned in order for the divestment penalty period to be eliminated. Connecticut, Florida, and Ohio will recalculate the penalty period when a portion is returned and eliminate the penalty period if all assets are returned. Two states have made changes to their policy dealing with the “intent” to divest in order to qualify for Medicaid.

Examples of how and when states will consider transfers to be divestments

- A divestment has occurred when a recipient takes action to make an asset unavailable; for example, adding another person’s name to an asset and the asset cannot be made available without that other person’s permission.
- The transfer is for less than fair market value; the transferor was not in good health at the time; and the transferor applied for Long-Term Care benefits under the Medicaid program within the look-back period.
- Whenever an individual sells, gives away, or reduces the individual’s ownership interest in a resource within the look-back period and fails to receive fair compensation.
- When it is made for inadequate consideration.

- The agency considers any transfer during the appropriate look-back period by the nursing-facility resident or spouse of a resource, or interest in a resource, owned by or available to the nursing-facility resident or the spouse (including the home or former home of the nursing-facility resident or the spouse) for less than fair-market value a disqualifying transfer unless listed as permissible in state laws. The agency may consider as a disqualifying transfer any action taken to avoid receiving a resource to which the nursing-facility resident or spouse is or would be entitled if such action had not been taken. Action taken to avoid receiving a resource may include, but is not limited to, waiving the right to receive a resource, not accepting a resource, agreeing to the diversion of a resource, or failure to take legal action to obtain a resource. In determining whether or not failure to take legal action to receive a resource is reasonably considered a transfer by the individual, the agency will consider the specific circumstances involved. A disqualifying transfer may include any action taken that would result in making a formerly available asset no longer available.
- Unless the person can establish that the transfer was solely for another purpose, or had a sudden onset of illness after the transfer, the transfer is considered to be for Medicaid purposes.
- Transfers are not considered a divestment if the transfer was solely for a purpose other than to qualify for Medicaid.
The Deficit Reduction Act Section 6062 created a new option for states to extend Medicaid coverage to children with disabilities. The new Medicaid coverage would create a “buy-in” opportunity for parents of children with disabilities with family incomes up to 300 percent of the federal poverty level (FPL). Under the DRA, coverage would be phased in starting in 2007 for children up to age 6 and coverage for children up to age 19 by 2009. Under the new section, states are allowed to charge premiums and require parents to participate in employer-sponsored insurance if the employer pays for at least 50 percent of the premium.

According to the results of the survey, three states plan to make this option available to such families and 28 states, Puerto Rico, and Guam do not plan to make this available. However, four states are still considering this option and three other states cover these individuals in another manner. One state plans to make this available in 2008 and another state is unsure when the Family Opportunity Act will be available. One state plans to set the income level up to 300 percent, another state up to 200 percent, and another state between 200 and 300 percent.

Finding 3—States Use Their Money Follows the Person Grant Dollars in Several Ways

The Money Follows the Person Demonstration Program authorizes the secretary of U.S. Health and Human Services to award competitive grants to increase the use of HCBS rather than the traditional institutional services. The demonstration program goal is to create an incentive for states to “rebalance” their long-term services programs by providing grant funding for two years. States who receive the grant awards will receive an enhanced match for each eligible individual that transitions from an institution to the community. States must, however, continue to support the individuals who have moved into the community setting after the two-year grant cycle ends. States are allowed to set criteria for eligibility but eligible individuals must have been institutionalized for at least six months and up to a max of two years. The total funding available for this demonstration program is $1.8 billion.

To date, 31 states have successfully competed for $1.4 billion in funding. Several states that received grant funds for Money Follows the Person have described how they plan to use these funds to assist nearly 38,000 individuals in their transition from institutional care to home- and community-based care.

Several states have targeted the populations include individuals with physical disabilities, the aging population, and individuals with traumatic brain injuries.

Oregon Money Follows the Person Initiative

Oregon plans to demonstrate that long-term institutionalized populations of people with complex medical and Long-Term Care needs can be served in their communities with wrap-around packages of supports and services. Specific populations that Oregon proposes to serve include:

- 40 children with developmental disabilities in pediatric nursing facilities
- 300 seniors with end-stage dementia in nursing facilities
- 300 adults with physical disabilities in nursing facilities; and
- 140 adults with developmental disabilities in nursing and intermediate care facilities.
These 780 individuals account for 16.5 percent of Oregon’s institutionalized Medicaid population. Staff in Oregon believe that the successful transition of these individuals to the community will begin building the next national model to provide HCBS to people not typically able to use these services.

**Texas Money Follows the Person Initiative**

Texas proposes to build on its current practice of assisting individuals to transition out of institutions into community-based programs and to focus new efforts on persons with complex support needs, particularly those with behavioral health conditions. This grant will provide Texas with the opportunity to conduct rebalancing efforts that would have been difficult without the additional federal funding. Texas is proposing a new strategy for transitioning individuals with intellectual and developmental disabilities out of community-operated nine-plus-bed Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) into the community with new demonstration services for persons with behavioral health conditions.

For individuals in nursing facilities, Texas will (1) build upon its current Money Follows the Person Initiative and use the enhanced match to finance community-based services and improve outreach efforts; (2) target for transition, individuals with complex support needs in general and (3) through a new pilot focused on individuals with co-occurring behavioral health conditions; and (4) provide post-transitional services to assist in a successful transition.

For individuals in institutions serving persons with intellectual and developmental disabilities, Texas will (1) continue its current Promoting Independence Priority Populations Initiative and use the enhanced match to transition individuals out of 14-plus-bed community-operated ICFs/MR and State Mental Retardation Facilities; and (2) implement a new initiative to close nine-plus-bed community-operated ICFs/MR and transition residents to other settings of their choice, including home- and community-based waiver programs.

**Washington State Roads to Community Living Project**

Washington’s Roads to Community Living will assist 660 citizens in Washington State who want to move from institutional settings to their own communities. Target groups for this project include older adults, individuals with developmental disabilities, individuals with physical disabilities, and individuals with mental illness who need extra services and support to move home. The project will provide intensive transition support and one-time goods and services needed to set up and maintain community living. The project includes strong partnerships with the Housing Trust Fund, local Housing Authorities, Vocational Rehabilitation, the Department of Mental Health, the Division of Developmental Disabilities, Tribal Nations, Area Agencies on Aging, the Associations of Centers for Independent Living, and other consumer advocacy groups in project design and implementation.
Finding 4—To Date, Most States are not Opting to Switch to the New HCBS State Plan Amendment (SPA) Option

The Deficit Reduction Act amends Section 1915 of the Social Security Act to allow for states to provide a comprehensive package of home- and community-based waiver services under their Medicaid state plan. Prior to the change in the DRA, states were only allowed to provide HCBS under a waiver.

There are a number of significant differences for states in using the new state plan option versus the HCBS waiver. Differences include limited services, awaiting federal guidance, and lack of flexibility to waiver comparability among populations, increased state costs, functional eligibility that is too restrictive, financial eligibility barriers, and financial constraints. (For a complete list of the differences between the new state plan option and the HCBS waiver, see Appendix B.)

At least two states plan to submit SPAs to provide HCBS, while 16 states and Guam are still unsure about whether they will submit an SPA for these services. As of the release of the survey, only Iowa has received approval for its new state plan amendment for HCBS.

**Select Services States May Provide under a HCBS SPA**

- Adult day health care
- Attendant care
- Companion care
- Emergency alert system
- Habilitation (day treatment and training, and supported employment)
- Home-delivered meals
- Home health services/home health aide
- Home health services/RN continuous and RN intermittent
- Home health services/LPN intermittent and LPN continuous
- Home modification
- Respite (short-term and continuous in-home and group respite)
- Assertive Community Treatment (ACT) services
- HCBS Partial Hospitalization
- HCBS Psychosocial Rehabilitation Services for individuals with Chronic Mental Illness

This list represents information only for states that responded to the survey.

**Eligibility for HCBS Services**

The DRA allows states to set eligibility for the new SPA HCBS up to 150 percent of the FPL. For the states considering the new state plan amendment for these services, one state plans to set the income level at 150 percent of FPL, one state is still unsure, and one state plans to set it at three times SSI eligibility limit.
Finding 5—States are Initiating Efforts to Transition Individuals Out of Institutions

A significant finding was that states are acting aggressively to move beneficiaries, when possible, from institutional settings to community settings. States are taking the following steps to move beneficiaries from institutions to community settings.

**State Innovations to Transition Individuals Out of Institutions**

- Establishing one-stop resource centers to provide a coordinated system of information and access for any person seeking Long-Term Care services and supports
- Developing web sites to provide up-to-date information on home- and community-based Long-Term Care services and supports
- Completing comprehensive studies to improve the state’s understanding of the financial and structural barriers to increasing access to HCBS
- Expanding funding to increase the number of frail and elder clients served by the programs currently offered
- Adding a relocation case management service to the Medicaid State Plan to assist people in moving out of institutions to community settings. This enabled the state to serve a broader group than individuals transitioning to home- and community-based waivers
- Creating a new Long-Term Care pre-admission screening tool
- Providing for transitional needs under a “Home Again” waiver
- Providing counseling and transition assistance to Medicaid beneficiaries residing in nursing homes who wish to return to the community
- Reviewing all Nursing Facility admissions at 45 days post admission; sending brochures with options and contacts to new admissions; instituting community transitional services into 1915(c) waivers; cooperating with centers for independent living
- Providing for “establishment” funds (e.g., furniture, lights, water, etc.)
- Establishing a portability program in which eligible individuals who have resided in a nursing home for 90 days or more may be transferred into the Waiver for Individuals with Physical Disabilities and having their funding follow them
- Approving spouses as paid caregivers and adding 24-hour in-home care in certain instances
- Collaborating with the nursing home ombudsman program to assist in transitioning individuals

Finding 6—States are Using Managed Care for Individuals with Disabilities

Of the states that responded to the survey, 13 and Puerto Rico indicated that they have a managed care program for individuals with disabilities on their Medicaid program. Five states’ managed care programs are within an HCBS waiver while eight states and Puerto Rico have a managed care program within their State Plan.
n the late 1990s with the assistance and support of the Robert Wood Johnson Foundation, Arkansas, Florida, and New Jersey were given special waiver authority to test the use of self-directed personal care services. Under the waiver program, these three states allowed beneficiaries to manage their personal assistance and other Long-Term Care services by “cashing out” the funds that they would have received from the states. The success of the three early implementer states led to the Independence Plus initiative, which encouraged all states to provide Medicaid beneficiaries with self-directed services. Independence Plus allows states to develop programs using either the 1115 or 1915(c) waiver authority.

The Deficit Reduction Act created another authority for states to provide self-directed personal care services under 1915 (j), but this time under a state plan amendment option. There are many differences between the waiver and SPA authorities, including the ability to waive statewideness and the ability to limit the program to certain populations. (For a complete comparison of the new SPA authority, Independence Plus waiver option, and the 1115 waiver, see Appendix C.)

At the time of the survey, only five states plan to submit a SPA for self-directed personal care services, that is, cash and counseling. States who chose this option believe the program will be helpful because it will give participants more flexibility and authority in the hiring and selection of their Long-Term Care providers. States also believe that providing participants with choices will lead them to make better decisions.

States moving toward the 1915(j) option include two states that are transitioning from a traditional 1115 waiver.

Twenty-five states currently offer personal care services and 8 states, Puerto Rico, and Guam do not. Of the 25 states, 18 states provide consumers with the option to hire/fire individual consumer-directed aides, and in 16 of these states this option is widely available. (Figure 6)

Eight states are considering a 1915(j) SPA to give those eligible for state personal care services the opportunity to direct an individual budget. Currently 26 states offer consumer-directed services within 1915(c) waivers for their elderly and/or disabled populations. Twenty-four states offer consumer-directed services within 1915(c) waivers for the Mentally Retarded/Developmentally Delayed population (MR/DD). (Figure 7)

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10 The data for this was collected prior to the release of the State Medicaid Director letter providing states with more information on the SPA for self-directed personal care services as well as a pre-print. NASMD will be investigating whether or not additional states will now take the option.
* Note: Puerto Rico and Guam do not have personal care services. New Jersey indicated that they have personal care services but did not state if they have or don’t have the option to hire/fire aids.
States Offering Consumer Directed Services within 1915(c) Waivers for the MR/DD Population

Legend:
- States that offer this option
- States that do not offer this option

*Note: Puerto Rico and Guam do not offer consumer directed services within 1915(c) waivers for the MR/DD Population.
Special Needs Plans (SNPs) are enrolling dual eligibles in 20 states and Puerto Rico. Puerto Rico and eleven of these states are contracting with SNPs for Medicaid services for dual eligibles. The states vary with regard to the populations enrolled in SNPs: two states cover duals over 21, one state covers those over 65, one state covers disabled persons between 18 and 64 and those over 65, one state covers all duals except those residing in institutions, one state covers aged/blind/disabled, one state covers both seniors and persons with disabilities, and one state covers the frail elderly who are physically disabled and are in nursing homes. States are working with nonprofit health plans, private health plans, their CMS regional offices, Medicare Advantage, managed care organizations, and other units of their state government to develop Special Needs Plans.

Sample Special Needs Plans Activities
Florida’s Nursing Home Diversion Waiver (1915(c)) offers acute and Long-Term Care services to dually eligible elders at risk for nursing home placement. Program providers are responsible for coordinating all the enrollee’s care needs regardless of funding source. Some Nursing Home Diversion plans have been certified as SNPs by Medicare. Florida’s Medicaid program is developing a program to serve dually eligible elders at risk for nursing home placement. This program will allow recipients to enroll simultaneously with the same Medicaid and Medicare Advantage managed care contractor. The new program will allow integration at the plan level. The new program’s contractors will contract with SNPs.

There are 12 dual-eligible SNPs currently operating in Minnesota and are sponsored by nine health plans, all of which also participate in Medicaid managed care. The state holds contracts with 10 of these SNPs. Nine of the SNPs serve over 35,000 dually eligible seniors under a fully integrated Medicare-Medicaid primary, acute, and Long-Term Care program called Minnesota Senior Health Options (MSHO). One SNP serves 800 people with disabilities age 18 to 64 enrolled in Minnesota Disability Health Options (MnDHO), also a fully integrated Medicare-Medicaid, primary, acute, and Long-Term Care program. The two other SNPs do not yet have contracts with the state, but one of them has enrolled over 600 dually eligible people with disabilities. The state currently has a solicitation pending for additional contracts with SNPs for a new primary and acute care program for people with disabilities age 18 to 64 called Special Needs BasicCare (SNBC), effective January 1, 2008.
Additional State Concerns with Special Needs Plans

- The SNP may not improve the coordination of care for Medicaid members since most Medicaid members are required to be enrolled in a Medicaid managed care organization.
- In states with a large managed care population, the SNP would not provide significant improvement with coordination of care.
- Service providers lack experience with Developmentally Delayed clients/Mental Health clients under 65, specifically as it pertains to targeted services coordination.
- Medicare-only SNPs that don’t have corresponding Medicaid contracts will cost-shift to Medicaid’s Long-Term Care systems.
- Failure to integrate Medicare and Medicaid payments and services results in fragmented care and poor clinical outcomes for frail dual eligibles.

- CMS has not provided enough specificity about coordination of care.
- The lack of provider network standards result in a wide variation among SNPs.
- SNPs are not available statewide, especially not in rural areas.
- The enrollment/disenrollment activities do not always coordinate from Medicare to Medicaid, causing gaps in coverage for clients.
- There need to be additional consumer protections regarding marketing to potential enrollees.

*As reported by States in the NASMD Survey on Long-Term Care*
**Note:** Puerto Rico has SNPs enrolling duals and is contracting with SNPs for medical services for duals. Guam does not have SNPs enrolling duals.
Finding 9—Long-Term Care Reform in the States Continues to Encourage Home- and Community-Based Living

States reported a wide range of Long-Term Care reform activities being implemented in the last year. Several states worked to ease the eligibility process by providing useful screening tools to potential beneficiaries. Several states indicated that they were engaged in Long-Term Care planning media awareness campaigns to encourage citizens to plan for their future health needs. One state indicated that it had undergone a major nursing home reform effort in the last year. The majority of states indicated that they were engaged in efforts to consolidate, coordinate, and improve home- and community-based services.

Sample State Long-Term Care Reform Initiatives

**New Jersey**—Governor Jon Corzine (D) signed the Independence, Dignity and Choice in Long-Term Care Act into law on June 21, 2006. The act calls for the reallocation of Medicaid Long-Term Care expenditures and the creation of a more appropriate balance between funding for nursing homes and community-based services. The program, known as Global Options for Long-Term Care (GO for LTC), is continuing the restructuring of New Jersey’s Long-Term Care system. The act also directs the Department of Health and Senior Services (DHSS) to implement a system of statewide Long-Term Care service coordination and management, identify home- and community-based Long-Term Care models that are efficient and cost-effective alternatives to nursing home care. DHSS will also develop and implement a consumer assessment instrument that is designed to expedite the process to authorize the provision of HCBS through fast-track eligibility prior to formal financial eligibility determination. In addition, DHSS is authorized to develop a quality assurance system, make information available to the general public, and create a Medicaid Long-Term Care Funding Advisory Council.

**Vermont**—Under Vermont’s 1115 waiver (Choices for Care), spouses may now be paid to provide care. Also, an option has been developed for 24-hour, in-home care, using a home provider or shared living arrangement. Vermont Medicaid carefully monitored several patients with mental health and Long-Term Care needs who left the state mental hospital for independent living environments to ensure that provisions for 24-hour care are realistic.

Over the next year, the states report that they have a series of Long-Term Care initiatives planned. Several states indicated that they were considering new initiatives on managed care for the elderly and disabled population. Some states indicated an interest in pursuing The Program of All-Inclusive Care for the Elderly (PACE). There is also significant interest in the states in pursuing additional self-directed options for beneficiaries.
Care coordination is a process that includes assessing the needs of a client and effectively planning, arranging, coordinating and following-up on services that most appropriately meet the identified needs of the client. States have used care coordination (for Medicaid recipients) to improve the quality of care that they receive.

One of the strongest trends identified in this survey was the use of care coordination to assist in the improvement and integration of care. At this time, at least 21 states have created some form of a care coordination model. The goal of these models is to improve and integrate care and each state has adopted unique features to cater to states individual needs.

(Figure 9)

**Examples of Care Coordination**

**Arizona**—The Arizona model serves people who are developmentally disabled, physically disabled, and/or elderly and who are at risk of an institutional level of care. All members are assigned a case manager to assist with the coordination of care. Members can move between HCBS and institutional settings as needed. The only restriction on HCBS is that the cost of care must be no more than the Medicaid cost of institutional care.

**California**—California will provide care coordination for individuals with chronic conditions who are seriously ill. The goal of the state’s new program is to enhance the coordination of care, improve health outcomes, and decrease the long-term costs of chronically ill populations by using a holistic approach. Interventions will include intensive case management and Disease Management strategies including: referrals to improve mobility and provide needed financial and social support, disease self-management education, development of individualized care plans using evidence-based practice guidelines, and promotion of the use of disease/patient registries to share data.

**Idaho**—The 2006 Idaho legislature directed the Department of Health and Welfare to increase its coordination with Medicare as part of the overall strategy for improving Medicaid efficiency and saving Medicaid funds. The Idaho benefit package coordinates and integrates benefits for individuals eligible for both Medicare and Medicaid. It is one of the three benefit packages that comprise Idaho’s Medicaid Modernization plan. Individuals who opt into the Medicare/Medicaid Coordinated Plan will receive an integrated benefits program offered by a participating Medicare Advantage Organization (MAO). Medicaid will pay the premium for the integrated Medicare Advantage Plan offered by a participating MAO. The integrated Medicare Advantage Plan will cover some services usually covered by Medicaid, such as primary care case management, prescribed drugs not covered by Medicare Part D, and dentures.

**Kentucky**—Kentucky’s plan focuses on combining the efforts of the private sector, universities, providers, and others to support the overall care coordination and utilization of supplies and services. Pilot, disease-specific programs have been established in the areas of Pediatric Asthma, Pediatric Obesity, Pediatric Diabetes, Diabetes, COPD/Asthma, Adult Obesity, and Health at Heart initiatives. Currently these are strictly Disease Management with plans to expand into a care coordination model.

**Maryland**—Maryland contracts for care coordination services for individuals in the Rare and Expensive Case Management Program. Care coordinators help develop plans of care and ensure that individuals receive a wider spectrum of Medicaid covered services if necessary.

**Massachusetts**—Massachusetts has a special care coordination plan for pediatric patients. Under the Massachusetts model, all Medicaid cases for children with complex care are managed by a care coordinator.

**Minnesota**—The state has a comprehensive care coordination model for seniors and people with disabilities that applies to enrollees in all settings (nursing home, waiver, and other community settings regardless of level of need). All enrollees are screened within 30 days of enrollment and are assigned a care coordinator or health service coordinator. The staff
assists in coordinating all aspects of care, including access to primary and specialty care, chronic care conditions, as well as to Long-Term Care, social and community support services. Most aspects of this care coordination are also found in the Minnesota Senior Care Plus (MSC+) program, which is a separate, mandatory managed care program that includes Medicaid wrap-around services and Long-Term Care but is not integrated with Medicare.

**New Jersey**—A part of the state’s GO for LTC program, the Nursing Home Transition initiative, implemented an interdisciplinary team approach to coordinate discharge planning for nursing home residents whose level of service needs can be supported with HCBS.

**North Dakota**—North Dakota has a primary care case management program that focuses on coordination of care for the elderly and disabled.

**Rhode Island**—The state’s care coordination program covers adults and elders with very high utilization in key diagnostic groups. The program will be significantly expanded effective September 1, 2007, by offering nurse care manager services to moderate and high-risk clients in primary care practice settings regardless of diagnosis.

**Vermont**—Vermont’s Chronic Care Program (CCP) focuses on Medicaid’s highest utilizers with chronic conditions. The CCP emphasizes evidenced-based planned and collaborative care for Medicaid beneficiaries. A registered nurse and a medical social worker team will be regionally based and work with care coordination clients and primary care providers directly.

Several additional states plan to create a care coordination model: Idaho, Louisiana, Maine, Nebraska, Ohio, Oklahoma, and Virginia.
Disease Management (DM) is defined as a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Chronic diseases such as diabetes, obesity, congestive heart failure, and untreated or under-treated asthma can lead to unnecessary hospitalizations and/or necessitate the need for Long-Term Care services. States have begun aggressive campaigns to monitor and prevent complications through care that includes helping patients to adhere to medication regimens to develop healthy lifestyle choices, and to seek regular professional monitoring of their symptoms.

At this time, at least 12 states have Disease Management programs that apply to their Long-Term Care settings, and numerous other states indicated that they are developing programs. Some of the states report limiting their DM programs to participants with certain chronic conditions or certain plans. Several additional states indicated that it was a requirement that the Managed Care plans that they contract with have Disease Management components. (Figure 10)

Selected State Disease Management Programs

Idaho’s current Disease Management program targets specific diseases of all participants. Long-Term Care participants receive their Disease Management services from their acute care provider even if they reside in a Long-Term Care setting.

Minnesota’s managed care contracts require Disease Management Programs for all enrollees. The state currently requires Disease Management Programs for diabetes and heart disease.

New Jersey’s Department of Health and Senior Services was awarded a three-year federal grant (Empowering Older People to Take More Control of their Health through Evidence-Based Prevention Programs). New Jersey was among 16 states selected to implement low-cost, community-based disease and disability prevention programs that have proven to reduce the risk of disease and disability among older adult participants. New Jersey is establishing the Chronic Disease Self-Management (CDSM) Program and Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) program.

North Dakota will be implementing Disease Management for all Medicaid recipients that have asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Heart Failure (CHF).

Tennessee’s Disease Management is applied across the board to its entire Medicaid population, including those who receive Long-Term Care services.

Texas HMOs must provide, or arrange to have provided to members, comprehensive Disease Management services consistent with state statutes and regulations. Such Disease Management services must be part of a person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. HMOs must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, or other chronic diseases based upon an evaluation of the prevalence of a disease within the
HMO's membership. The HMO must ensure that all members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining to access to all other covered services. The DM Programs must include: (1) patient self-management education; (2) provider education; (3) evidence-based models and minimum standards of care; (4) standardized protocols and participation criteria; (5) physician-directed or physician-supervised care; (6) implementation of interventions that address the continuum of care; (7) mechanisms to modify or change interventions that are not proven effective; and (8) mechanisms to monitor the impact of the DM program over time, including both the clinical and the financial impact.

**Virginia’s Healthy Returns program** provides Disease Management support to individuals who are receiving home- and community-based waiver services. Conditions covered include asthma, diabetes, congestive heart failure, coronary artery disease, and COPD.
Finding 12—Many States are Using the New Option on Long-Term Care Partnership Programs

In the 1980s, the Robert Wood Johnson Foundation (RWJF) provided grants to states to support the development of a unique insurance model that encourages consumers to purchase Long-Term Care insurance. The program allows states to promote the purchase of LTC insurance by offering access to Medicaid under special eligibility rules should additional LTC coverage (beyond the terms in the LTC insurance contract) be needed. The original demonstration model has been underway since 1992 in California, Connecticut, Indiana, and New York. The Deficit Reduction Act lifted the technical barriers Congress had imposed on such programs, allowing for the expansion of the LTCPP to other states.11

The LTCPP was designed to attract consumers who might not otherwise purchase LTC insurance. States offer the guarantee that if benefits under a LTCPP policy do not sufficiently cover the cost of care, the consumer may qualify for Medicaid under special eligibility rules while retaining a pre-specified amount of assets. Consumers are protected from having to become impoverished to qualify for Medicaid, and states avoid the burden of Long-Term Care.

According to the Center for Health Care Strategies, 17 states are currently making efforts toward Partnership program implementation. Of the 17 states, 12 states already have approved state plan amendments.12 (Figure 11)

11 Long-Term Care Partnership Expansion: A New Opportunity for States, CHCS, NASMD, and George Mason University, May 2007
12 http://www.rwjf.org/programareas/resources/product.jsp?id=18647&pid=1144
FIGURE 11
State Long-Term Care Partnership Program Progress*

LEGEND:
- Original Long-Term Care Partnership state
- Long-Term Care Partnership Expansion grantee (RWJF/CHCS initiative)
- Additional states planning for a Long-Term Care Partnership Program
- Approved State Plan Amendment for Long-Term Care Partnership Program

* Data is unavailable for Puerto Rico and Guam.

* State Long-Term Care Partnership Program Progress, CHCS, August 2007.
Finding 13—Benchmark Benefit Packages are not Widely Used for Long-Term Care services

At this time four states have adopted a DRA benchmark benefit package for Long-Term Care services. Idaho and Kentucky provided comprehensive Long-Term Care reform benefit packages while Virginia and Washington provided Disease Management.

Alternative Benefit Packages under the Deficit Reduction Act

Section 6044 of the Deficit Reduction Act provides states with the flexibility to change their Medicaid benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements. Certain groups are protected from changes under the benchmark benefit packages. States may use these packages for alternative benefits, such as providing Disease Management Services or other services to members on a voluntary basis.13

Some of the reasons states cited for not considering using the DRA benchmark benefit packages include other Long-Term Care priorities; the need for legislative approval before making such a change; the limited availability for populations; and in certain jurisdictions Long-Term Care is not covered and the funds are not available to add it. In addition, there is a limited understanding of how to use the new benchmark flexibilities under the DRA.

Idaho’s Medicaid reform initiative used the DRA benchmark benefit flexibilities and divided the state program into three programs, including one for children and working age adults, one for individuals with disabilities, and one for individuals on both Medicaid and Medicare. Idaho’s reform initiative sought to encourage preventive treatment but also providing additional tailored benefits to individuals with disabilities and the elderly. The programs for the disabled and elderly included enhanced services such as primary care case management, dental, vision, transportation, extensive mental health services, services for individuals with developmental disabilities, and targeted case management.

Kentucky’s current KYHealth Choices includes four benchmark programs to cover all populations and existing services within the state of Kentucky.

- Global Choices covers the general Medicaid population;
- Family Choices covers most children, including the Kentucky Children’s Health Insurance Program (KCHIP) population;
- Optimum Choices covers Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care individuals with mental retardation and development disabilities, including those in the Supports for Community Living (SCL) waiver;
- Comprehensive Choices covers nursing facility level of care individuals who are disabled, including those in the Acquired Brain Injury, Home- and Community-Based, and Model II (Ventilator Dependent) waivers.

Optimum Choices and Comprehensive Choices under the new Kentucky plan cover Long-Term Care services. The entire Kentucky Medicaid redesign was structured to ensure a continuum of care that maximizes the use of services provided at home.14

Virginia and Washington have SPAs under the new DRA benchmark benefit package design to tailor Disease Management Programs. Washington submitted a request to offer regular Medicaid services plus Disease Management Services to adult Medicaid recipients with complex medical needs who are diagnosed with certain chronic medical conditions, including diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, and chronic pain associated with musculoskeletal conditions and other chronic illness. According to the Washington SPA approval notification, the benchmark services will benefit Medicaid recipients in the following ways:

13 For additional information, see www.cms.hhs.gov.

14 For additional information on the KYHealth Choices, see http://chfi.ky.gov/NR/rdonlyres/70AC8C04-8DEF-4A64-AB06-45FEE8285A04/0/1115waiver.pdf.
■ Assist individuals in locating a medical home primary care provider (PCP) and learning to use the PCP appropriately;

■ Increase the ability of individuals to follow their provider’s prescribed plan of care and to play a more proactive role in their own health care through education about their chronic conditions, and helping them to become more efficient consumers of the health care system;

■ Support primary care providers by providing their patients with chronic conditions access to nurse help lines and referrals for needed services; and

■ Provide feedback from patients about their health activities to the primary care providers to help facilitate changes to a patient’s plan of care.

Beneficiaries in the Washington plan will receive the following additional benefits: education about their specific condition; access to a nurse call line; regularly scheduled telephone calls providing health care management and support; and care coordination, including feedback to the primary care physician.

Virginia’s Healthy Returns Benchmark Benefit SPA was approved in March 2007 and provides Medicaid recipients with asthma, congestive heart failure, coronary artery disease, and/or diabetes an additional set of services. All Medicaid enrollees are eligible to participate in the Healthy Returns initiative except those who are enrolled in managed care, are dual eligibles, live in institutional settings, or who have third party insurance. The program will provide recipients with condition-specific education, access to a 24-hour nurse call line, regularly scheduled telephone calls with health support, and care coordination to the primary care physician. Virginia is hoping to enroll 25,000 participants in the program.
Policy and Practice Outlook

This report provides a detailed snapshot of state actions in Medicaid Long-Term Care during the late summer of 2007. As states gain experience using the Deficit Reduction Act (DRA, P.L. 109-171) provisions, this document will help policymakers and Medicaid stakeholders assess the impact of this landmark legislation on state Long-Term Care policies and practices.

The Deficit Reduction Act made several major changes to Long-Term Care services in both how states can provide the services and who is eligible for those services. States were required to tighten their eligibility rules to the Medicaid program by changing the penalties, changing the methodologies for counting assets, and excluding individuals with higher home equities from coverage. By tightening the eligibility rules, both states and the federal government hope to ensure that those individuals who are eligible are enrolled and cared for under the Medicaid program. However, the states and federal government also have an interest in ensuring that those who have divested their assets in the past in order to qualify for the program are no longer able to do so.

The DRA also created a series of opportunities for states to encourage more home- and community-based opportunities for individuals with disabilities and illness. Through the Money Follows the Person Demonstration programs and the cash and counseling state plan option, states will continue to expand their efforts to move individuals out of institutions. As the federal grant dollars disappear over the next year or two, one policy question already being debated is, will the states have the funding and infrastructure necessary to keep individuals who desire to remain in their communities after the federal demonstration funding is no longer available.

The DRA also offered states the opportunity to promote the purchase of LTC insurance by offering access to Medicaid under special eligibility rules should additional LTC coverage (beyond the terms in the LTC insurance contract) be needed. Many states already have taken up the opportunity to offer this program, with still more states planning to do so in 2008. Whether or not this program can keep individuals off the Medicaid program for longer, however, remains in question.

Another significant finding of the report was the number of states working on preventing the need for LTC services through the use of aggressive care coordination programs and Disease Management strategies. The outcome of these efforts will not be known for years, but early indications are that they can improve outcomes for patients while also saving the programs money.

It is too soon to assess the impact that the DRA had on Long-Term Care reforms and the Medicaid programs. Many states are still interpreting the guidance from CMS and trying to determine what it means for their individual state and what initiatives they will take. A tightening of some of the states’ budgets may also stall efforts to develop comprehensive Long-Term Care strategy.

Finally, as Congressional leaders signal their willingness to reform additional areas of Long-Term Care in the Medicaid programs, Medicaid directors and state policymakers will be interested in the direction that Congressional leaders take. The Presidential race also will likely enter into the debate as many of the candidates have indicated that health care reform will top their agendas.
Activities of Daily Living (ADLs)
Basic personal activities, which include bathing, dressing, transferring from bed to chair, toilet assistance, mobility, and eating. ADLs are used to measure how dependent a person may be on requiring assistance in performing any or all of these activities.15

Asset Transfers Requirement
Requires states to lengthen the look-back period for asset transfers to establish Medicaid eligibility for nursing home coverage from three to five years and changes the start of the penalty from the date of the transfer to the date of Medicaid eligibility; requires annuities to be disclosed and states to be named a beneficiary for cost of Medicaid assistance; requires state to use the income-first rule; and excludes coverage for individuals with home equity in excess of $500,000 (or up to $750,000 at state option), with an exception when a spouse or child with a disability is residing in the home.16

Care Coordination
The goal of care coordination is to improve and integrate the care while reducing the unnecessary consumption of services. Some models focus more on the medical care and are often created for certain populations while other models combine both the medical and Long-Term Care needs; others focus on screening and care planning.

Cash and Counseling
A program that gives elderly and disabled Medicaid consumers who receive personal assistance services the option of directing their own care. These services include help with everyday needs like bathing, dressing, grooming, cooking, and housekeeping. Traditionally, state Medicaid programs have contracted with home care agencies to provide these services. Although consumers may choose from among available agencies, they often have little say in who will provide these very personal services. By redirecting personal assistance funds from agencies to consumers themselves, Cash and Counseling allows people to hire whomever they want to provide their care and decide for themselves if they would rather purchase a microwave oven to heat up their meals or hire an aide to cook for them.17

Cash and Counseling does not increase states’ Medicaid costs if people receive the care to which they are entitled under the traditional system. This conclusion is based on the findings of the evaluation of the original Cash and Counseling Demonstration and Evaluation programs in Arkansas, Florida, and New Jersey. Cash and Counseling intends to increase consumer satisfaction, quality, and efficiency in the provision of personal assistance services.

Consumer Choice
This is provided when there is a range of service options to meet the diverse needs of consumers. The degree to which consumers have choice must go beyond the range of service choices and include opportunities for consumers to decide when and where services will be provided, and how and by whom tasks will be performed.18

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17 (C&C FAQs available at http://www.cashandcounseling.org/about/FAQ)
**Consumer-Directed Programs**

Consumers can decide which services to use, which workers to hire, and what time of day they will come. They can decide whether to hire family members and whether to spend the available funds on things other than services (like appliances or home modifications). In some consumer-directed programs, consumers pay their workers themselves; in others, consumers choose to have an “intermediary service organization” handle payments.19

**DRA Annuity Requirements**

Applicants must disclose to the state any interest the applicant or spouse has in the annuity; the state must be named as remainder beneficiary if the applicant or spouse is the annuitant; new provisions for the treatment of the purchase of certain annuities as a transfer for less than fair market value.20

**Disability**

“With respect to an individual, (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having an impairment.” (ADA, 42 USC 12102)

“The phrase physical impairment includes but is not limited to … orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism… The phrase ‘major life activities’ means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working” (ADA Handbook, pp. II-16 through II-19).21

**Disease Management**

Disease Management is defined as a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.

**Dual Eligibles**

Individuals with certain combinations of needs who enroll in both the state-administered Medicaid program and the federally administered Medicare program are referred to as dual eligibles. Currently, dual eligibles (sometimes referred to as “duals”) receive prescription drugs and most Long-Term Care benefits from Medicaid, while they are covered by Medicare for acute benefits such as doctor’s visits and inpatient hospital care.22

**Family Opportunity Act**

Creates a new option for states to extend Medicaid “buy-in” coverage to children with disabilities with family income up to 300 percent of poverty.23

**FFP**

Federal Financial Participation.24

**Fiscal Intermediaries**

Organizations that provide third-party and fourth-party financial services between recipient and providers of a benefit.25

**FMAP**

Federal Medical Assistance Percentage.26


21 (Clearinghouse for the Community Living Exchange Collaborative glossary, [http://www.hcbs.org/glossary.php](http://www.hcbs.org/glossary.php))

22 (Clearinghouse for the Community Living Exchange Collaborative glossary, [http://www.hcbs.org/glossary.php](http://www.hcbs.org/glossary.php))

23 (Kaiser Family Foundation, Medicaid/SCHIP: Long-Term Care Medicaid Long-Term Services Reforms in the Deficit Reduction Act, 2006, [http://www.kff.org/medicaid/7486.cfm](http://www.kff.org/medicaid/7486.cfm))

24 (Clearinghouse for the Community Living Exchange Collaborative glossary, [http://www.hcbs.org/glossary.php](http://www.hcbs.org/glossary.php))

25 ibid

26 ibid
Home- and Community-Based Services (HCBS)

Home- and Community-Based Services are services or other supports to help people with disabilities of all ages to live in the community. Each state has a mix of programs and funding sources. The Medicaid program pays for many of these services in all states.27

Home- and Community-Based Waivers

Section 2176 of the Omnibus Reconciliation Act of 1987 permits states to offer, under a waiver, a wide array of home- and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as home- and community-based services that may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care, and other services.28

Home Equity Provision

The DRA imposes a limit of $500,000 on the value of an individual’s home equity. States may increase this up to $750,000.29

Income First Rule

As required by the DRA, this is the amount of the institutionalized spouse’s income that would be made available to the community spouse before computing the amount of additional resources that would be required to bring the community spouse’s income up to the standard.30

Level of Care (LOC)

Amount of assistance required by consumers, which may determine their eligibility for programs and services. Levels include protective, intermediate, and skilled.31

Long-Term Care (LTC)

Range of medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short- or long-term and may be provided in a person’s home, in the community, or in residential facilities (e.g., nursing homes or assisted living facilities).32

Look-Back Period

This was lengthened from 36 months to 60 months as a result of the DRA.33

Money Follows the Person Demonstration

Authorizes the secretary of U.S. HHS to grant competitive awards to states to increase the use of community versus institutional services, and provides for an enhanced federal medical assistance percentage (FMAP) for 12 months for each person transitioned from an institution to the community during the demonstration period. Eligible participants must have resided in an institution for a period from 6 months to 2 years, as determined by the state, and states must continue to provide community services after the demonstration period for as long as the individual remains on Medicaid and in need of community services.34

27 ibid
28 ibid
32 ibid
34 (Kaiser Family Foundation, Medicaid/SCHIP: Long-Term Care Medicaid Long-Term Services Reforms in the Deficit Reduction Act, 2006, http://www.kff.org/medicaid/7486.cfm)
The federal government will pay for 75 to 90 percent of the costs of transitioning individuals out of nursing homes and into the community. The following states received grants for this demonstration program: Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin.35

Partial Month Penalties
As a result of the DRA, states must impose partial month penalties for transfers that are less than the average cost of care for one month.36

Penalty Period
As a result of the DRA, the penalty period now begins on whichever occurs later of the date of transfer or the date the individual would otherwise be eligible for Medicaid coverage of Long-Term Care.37

Personal Assistance Services (PAS)
Personal Assistance Services include many different kinds of assistance to people with disabilities who need help with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs).38

Personal Care
Personal care is defined as assistance with activities of daily living as well as with self-administration of medications and preparation of special diets (also called custodial care).39

Service Coordinators
These assist consumers to assess their need for services, arrange and coordinate the services, and monitor the services. Different programs use different terms, including “case managers,” “care managers,” and “service brokers.” Case manager is the term for “service coordinator” used by the Medicaid Program and some state HCBS programs.40

Special Needs Plans (SNPs)
SNPs provide an opportunity to integrate care and provide benefits to certain populations that have been identified as institutionalized beneficiaries; beneficiaries who are dually eligible for Medicare and Medicaid; and beneficiaries with severe or disabling chronic conditions. Plans can limit enrollment to one of the special needs populations and tailor the benefits and provider networks to meet the needs of specific groups.

40 ibid
State Option to Provide HCBS Services

DRA Section 6086, also known as SSA Section 1915(i), allows states the opportunity to submit a State Plan Amendment (SPA) to provide home- and community-based services for elderly and disabled individuals. This creates a new state option for states to provide all HCBS waiver services without needing to get a waiver for seniors and people with disabilities up to 150 percent of poverty; there is no requirement that eligible beneficiaries require an institutional level of care. It also requires states to establish more stringent eligibility criteria for institutional services and permits states to cap enrollment, maintain waiting lists, and offer the option without providing services statewide.41

Undue Hardship

The DRA requires states to have undue hardship provisions that allow the state to waive a penalty period when an individual would be deprived of medical care such that his/her life or health would be endangered or that the individual would be deprived of food, clothing, shelter, or other necessities of life.42

1915 (c) waiver

The 1915(c) waiver for Medicaid home- and community-based services waivers that allow states to request waivers of certain federal requirements to allow development of HCBS treatment alternatives to institutional care so long as these alternatives cost no more than it would to provide the same care in an institutional setting.43


APPENDIX A:
State Citations on DRA Implementation

References to state laws, regulations, and/or policies regarding implementation of the DRA §6011 (look-back period):

AK: 7 AAC 100.510(c)
AR: Supplement 9(b) to attachment 2.6A pages 1 – 7 of the Arkansas State Plan
CT: UPM 3029; five year look back to be phased in
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (IDAPA 16.03.05.833)
KY: 907 KAR 1:650
MA: Regulations revised at 130 CMR 520.019 (B).
MN: Minn. Stat. §256B.0595
NE: 469 NAC 2-009.10B3a
OR: Oregon Administrative Rule(OAR)461-140-0210
RI: Medicaid Policy 384
VT: Rule M440.5(a)
VA: 12VAC30-40-300
WA: Washington Administrative Code 388-513-1363

References to state laws, regulations, and/or policies regarding implementation of DRA §6011 (penalty period):

AK: 7 AAC 100.510(g)
AR: Supplement 9(b) to attachment 2.6A pages 1 – 7 of Arkansas State Plan
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.835)
KY: 907 KAR 1:650
MA: Revised regulations revised at 130 CMR 520.019 1(3).
MN: Minn. Stat. §256B.0595
NE: 469 NAC 2-009.10B3b
OR: OAR 461-140-0296
RI: Medicaid Policy 384
VT: Rule M440.41
VA: 12VAC30-40-300
WA: Washington Administrative Code 388-513-1363
References to state laws, regulations, and/or policies regarding implementation of DRA §6016 (partial months of ineligibility):

AK: 7 AAC 100.510(c)(3)
AR: Supplement 9 (b) to attachment 2.6A pages 1 – 7 of Arkansas State Plan
CT: UPM 3028; 3029
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.834)
MA: Revised regulations at 130 CMR 520.019 ©(d).
MT: Administrative Rules of Montana 37.82.101
NE: 469 NAC 2-009.10B3b
ND: N.D.A.C. 75-02-02.1-33.1
OR: OAR 461-140-0296
RI: Medicaid Policy 384
VA: 12VAC30-40-300

References to state laws, regulations, and/or policies regarding implementation of DRA §6016 (accumulating multiple transfers):

AK: 7AAC 100.510 (f)
AR: Supplement 9(b) to Attachment 2.6A, pages 1 – 7 of Arkansas State Plan
CT: UPM 3029
DE: DSSM 20350.4
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.835)
MA: Revised regulations at 130 CMR 520.019 (G)(2)(i).
MN: Minn. Stat. §256B.0595
MT: ARM 37.82.101 already opted in State Plan
NE: 469 NAC 2-009.10B3b
OR: OAR 461-140-0296
RI: Medicaid Policy 384
WA: Washington Administrative Code 388-513-1363
References to state laws, regulations, and/or policies regarding implementation of DRA §6016 (purchasing of promissory notes, mortgages, loans):
AK: 7 AAC 100.510(k)(10)
AZ: ARS 36-2934.02
AR: Medical Services Policy MS 06-09 dated 10-1-06
CT: Uniform Policy Manual 3029.14
DE: DSSM 20330.3
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.831)
KY: 907 KAR 1:650
MA: Revised regulations at 130 CMR 515.001 (J).
MN: Minn. Stat. §256B.0595
NE: 469 NAC 2-009.07B10
OR: OAR 461-0145-0330
RI: Medicaid Policy 384
VT: Rule M440.36
VA: 12VAC30-40-300

References to state laws, regulations, and/or policies regarding implementation of DRA §6016 (purchasing of life estates):
AK: 7 AAC 100.512(c)
AR: Medical Services Policy 06-09 dated 10-1-06
CT: UPM 3029.13
DE: DSSM 20320.2.2
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.247)
KY: 907 KAR 1:585
MA: Revised regulations at 130 CMR 520.019 (I).
MN: Minn. Stat. §256B.0595
NE: 469 NAC 2-009.07B8
OR: OAR 461-145-0310
RI: Medicaid Policy 384
VT: Rule M440.32
VA: 12VAC30-40-290
WA: Washington State will be strengthening our regulations, but current regulations allow us to deny these transfers as invalid.
References to state laws, regulations, and/or policies regarding implementation of DRA §6011 (Hardship Waivers):

AK: 7 AAC 100.512(c)
AR: Medical Services Policy 06-09 dated 10-1-06
CT: UPM 3029.13
DE: DSSM 20320.2.2
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.247)
KY: 907 KAR 1:585
MA: Revised regulations at 130 CMR 520.019 (I).
MN: Minn. Stat. §256B.0595
NE: 469 NAC 2-009.07B8
OR: OAR 461-145-0310
VT: Rule M440.32
VA: 12VAC30-40-290
WA: Washington State will be strengthening our regulations, but current regulations allow us to deny these transfers as invalid.

References to state laws, regulations, and/or policies regarding implementation of DRA §6012 (annuities):

AK: 7 AACA 100.514(7)
AR: Supplement 9(b)-Attachment 2.6A pages 1–7
CT: UPM 3029
DE: DSSM 20330.4.1
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.838)
KY: 907 KAR 1:650
MA: Revised regulations at 130 CMR 515.001 (I)(2)(a)(i).
MN: Minn. Stat. §§256B.056 and 256B.0594
NE: 469 NAC 2-009.07A5c(2)
OH: Ohio Administrative code 5101:1-39-22.8
OR: OAR 461-145-0022
RI: Medicaid Policy 384
TN: Department of Human Services Rules filed as Public Necessity effective June 1, 2007
TX: TAC Title 1 Part 15 Chapter 358 Subchapter D Rule §358.431
VT: Rule M440.34
VA: 12VAC30-40-10
References to state laws, regulations, and/or policies regarding implementation of DRA §6013 (income first rules):

AK: 7 AAC 100.560
CT: UPM 1570.25
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.744)
MA: Regulations at 130 CMR 520.017 (C).
NE: 469 NAC 2-010.01D
OH: 12/01/06 Ohio Administrative Code 5101: 1-39-24
OR: OAR 461-160-0580
RI: Medicaid Policy 380
VA: 12VAC30-110-960
WA: Washington Administrative Code 388-513-1325 (see also 1315 and 1330) Washington State already uses the income first method.

References to state laws, regulations, and/or policies regarding implementation of DRA §6014 (home equity):

CT: UPM 4030.20
ID: http://adm.idaho.gov/adminrules/rules/idapa16/0305.pdf (16.03.05.238)
MA: Revised regulations at 130 CMR 515.001 (G) (3).
MT: ARM 37.82.101
NE: 469 NAC 2-009.07B1c
OH: Ohio Administrative Code 5101:39-31
OR: OAR 461-145-0220
RI: Medicaid Policy 384
VT: Rule M233.26
WA: Home Equity in RCW 74.04.005; Washington Administrative Code 388-513-1350
**APPENDIX B:**
Section 6086: Home- and Community-Based Services

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>State Plan Option—1915(i)</th>
<th>Waiver Option—1915(c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>No set or limited time period, and does not need to be renewed or re-reviewed.</td>
<td>Waivers are approved for a specific time period (3 or 5 years), and need to be renewed (and re-reviewed) when this period is over.</td>
</tr>
<tr>
<td>Level of care requirement</td>
<td>No “level of care” requirement for participants.</td>
<td>Includes “level of care” requirements.</td>
</tr>
<tr>
<td>Comparability</td>
<td>Can limit the number of participants, and can create waiting lists, but can not waive comparability.</td>
<td>Can waive comparability. States can create waiting lists.</td>
</tr>
<tr>
<td>Statewideness</td>
<td>Can waive statewideness.</td>
<td>Can waive statewideness.</td>
</tr>
<tr>
<td>Eligibility restrictions</td>
<td>Cannot expand eligibility, income of participants can not exceed 150% FPL.</td>
<td>Can waive income limits, expand eligibility criteria. States must submit eligibility and any applicable post-eligibility criteria.</td>
</tr>
<tr>
<td>Needs-based criteria</td>
<td>States must establish needs-based criteria, but needs-based criteria for participants must be less stringent than for institutional-level care.</td>
<td>Does not include this requirement.</td>
</tr>
<tr>
<td>Cost-neutrality</td>
<td>Does not include requirement of cost-neutrality. The state plan must describe the method used for calculating the budget and define a process for making adjustments and for evaluating expenditures.</td>
<td>Must be cost-neutral.</td>
</tr>
<tr>
<td>Characteristic</td>
<td>State Plan Option—1915(i)</td>
<td>Waiver Option—1915(c)</td>
</tr>
<tr>
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<tr>
<td>Required services</td>
<td>States have discretion over what are required services, although they can only choose from a limited list of services authorized by Section 1915(c)(4)(B) of the Social Security Act. This section gives 1915(c) waiver authority to “provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.” Under 1915(i) states may not cover “other” services authorized under 1915(c)(4)(B).</td>
<td>States may provide any or all of the following services: case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. States can request approval to provide other services that participants may need to avoid being placed in a medical facility (such as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care).</td>
</tr>
<tr>
<td>Reporting of projected participation</td>
<td>States must submit to CMS the projected number of individuals who will receive HCBS under the state plan option.</td>
<td>States must submit the number of participants expected to be served under the waiver.</td>
</tr>
<tr>
<td>Data reporting requirements</td>
<td>N/A</td>
<td>States are required to provide the federal government with annual data on the impact of the waiver, including the types and amount of services provided and beneficiary information.</td>
</tr>
<tr>
<td>Characteristic</td>
<td>State Plan Option—1915(i)</td>
<td>Waiver Option—1915(c)</td>
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</tr>
<tr>
<td>Modification of needs-based criteria</td>
<td>States have the authority to modify their needs-based criteria for eligibility without prior approval from CMS if enrollment exceeds projected capacity. In this case, the state must notify the public and CMS of the change at least 60 days before it occurs.</td>
<td>N/A</td>
</tr>
<tr>
<td>Individual evaluation</td>
<td>States must conduct an evaluation to determine individual eligibility.</td>
<td>States must conduct an evaluation to determine individual eligibility.</td>
</tr>
<tr>
<td>Individualized needs assessments</td>
<td>States must conduct individualized needs assessments.</td>
<td>States must conduct individualized needs assessments.</td>
</tr>
<tr>
<td>Individualized care plans</td>
<td>States must establish a written individualized care plan. The plan must be developed in consultation with the individual, the individual’s physician, and other health care support professionals, and, if appropriate, the individual’s family. The plan is to be reviewed annually and as needed based on the individual’s circumstances.</td>
<td>States must establish a written individualized care plan.</td>
</tr>
<tr>
<td>Self-directed service option</td>
<td>States may provide the option for self-directed services.</td>
<td>Self-direction is not required for the basic 1915(c) waiver, but is an option that states may elect. Self-direction is a requirement for the Independence Plus 1915(c) waiver.</td>
</tr>
<tr>
<td>Quality assurance</td>
<td>Includes quality assurance provisions based on federal and state guidelines.</td>
<td>Includes quality assurance provisions based on federal and state guidelines. In addition, waivers must provide evidence that the statutory and regulatory assurances have been met (i.e., health and welfare, qualified providers, etc).</td>
</tr>
<tr>
<td>Characteristic</td>
<td>State Plan Option—1915(i)</td>
<td>Waiver Option—1915(c)</td>
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<tr>
<td>Redetermination</td>
<td>Redeterminations must be conducted on at least an annual basis. Redeterminations and appeals must be allowed in accordance with the Medicaid State Plan.</td>
<td>Redeterminations can be conducted no less than annually.</td>
</tr>
<tr>
<td>Presumptive eligibility</td>
<td>States may elect to provide a period of presumptive eligibility for up to 60 days. Payment must be limited to medical assistance associated with the independent, individualized evaluation and assessment.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### APPENDIX C:
Section 6087: Self-Directed Personal Assistance Services (PAS) and “Cash and Counseling”

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Section 6087 of the DRA (Self-Directed State Plan Option, Section 1915(j) of the Social Security Act)</th>
<th>Independence Plus (IP) demonstrations and waivers</th>
<th>Existing State Plan Personal Care Services (PCS) Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparability and statewideness</td>
<td>Can waive comparability and statewideness (targeting specific populations, limiting participant numbers, and limiting to specific geographical locations).</td>
<td>Can waive comparability and statewideness under the IP Section 1115 demonstrations and Section 1915(c) waivers.</td>
<td>Must meet requirements for comparability and statewideness.</td>
</tr>
<tr>
<td>Level of care eligibility requirements</td>
<td>The State Plan option does not change existing eligibility requirements of State Plan personal care services or 1915(c) HCBS waiver services.</td>
<td>Under the Section 1115 option, individuals do not have a level of care requirement for participation. Under the Section 1915(c) option, individuals must meet the need for an institutional level of care for participation. In addition, individuals must fit into one of the following population categories or a subgroup: Aged/Disabled; Mentally Retarded/Developmentally Disabled; or Mentally Ill.</td>
<td>Personal care services (PCS) must be provided in the home but at State’s option may also be provided in other locations. (from 42 CFR 440.167) Allowable services may be in the form of hands-on assistance (actually performing a personal care task for a person) or cueing so that the person performs the task by him/her self. (These tasks include Activities of Daily Living (ADLs) such as eating, bathing, dressing, toileting, transferring, and maintaining continence, as well as Instrumental Activities of Daily Living (IADLs), which are more complex life activities, including: personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.) (from Medicaid Manual Section 4480)</td>
</tr>
<tr>
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<tr>
<td>Residential requirements</td>
<td>Services provided under this state plan option cannot be provided to individuals residing in a setting owned, operated or controlled by a provider of services not related by blood or marriage.</td>
<td>Individuals must reside in their own homes, with their families or in a living arrangement where services are furnished to fewer than four persons unrelated to the proprietor.</td>
<td>PCS may be furnished to individuals who are not inpatients or residents of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.</td>
</tr>
<tr>
<td>Health and welfare and financial safeguards</td>
<td>States must assure they have safeguards to protect health and welfare beneficiaries and ensure financial accountability.</td>
<td>For Section 1115 demonstrations and Section 1915(c) waivers, states are required to have safeguards to protect health and welfare, including information and assistance in support of self-direction and financial management services. In addition, States must have a Quality Management System in place that includes an incident reporting and management system.</td>
<td>States maintain responsibility for ensuring that providers meet state provider qualifications and for monitoring service delivery. States must develop provider qualifications for providers of personal care services and establish mechanisms for monitoring the quality of the service.</td>
</tr>
<tr>
<td>Safeguard requirements</td>
<td>Quality assurance and risk management techniques must be in place to establish and implement the service plan and budget. (See also box below and box on support system.)</td>
<td>For Section 1115 demonstrations and Section 1915(c) waivers, states are required to describe incident management systems, if they are present, provide for emergency backup as part of the individual’s plan of care, and describe other participant safeguards.</td>
<td>States can opt to provide various safeguard measures, including criminal record checks and training, for PAS providers.</td>
</tr>
<tr>
<td>Characteristic</td>
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</tr>
<tr>
<td><strong>Financial accountability</strong></td>
<td>States must ensure financial accountability measures are in place to obtain federal approval.</td>
<td>Under the Section 1115 demonstration and 1915(c) waiver options, states must assure financial accountability for 1115 demonstration or HCBS waiver expended funds. In addition, states must maintain and make available to the federal government financial records and audit reports.</td>
<td>States must expend, report, and account for Medicaid funds according to Medicaid requirements governing State Plans.</td>
</tr>
<tr>
<td><strong>Individualized evaluation</strong></td>
<td>States will provide an assessment of the needs, strengths and preferences of the participants for PAS services, and develop and approve a service plan, along with supports for such services. The service plan is developed using a person-centered process.</td>
<td>Individualized plans must be developed through a person-centered approach.</td>
<td>States have the option to allow PCS to be otherwise authorized in accordance with a service plan approved by the state (i.e., it is no longer required that PCS need be prescribed by a physician in accordance with a plan of treatment). (from 42 CFR 440.167)</td>
</tr>
<tr>
<td><strong>Option for self-direction</strong></td>
<td>Individuals determined to meet needs-criteria must be informed of the option of self-directed PAS (as opposed to receiving services under the Medicaid plan or through a HCBS waiver).</td>
<td>Section 1115 demonstrations and Section 1915(c) IP waivers require that participation be voluntary and informed.</td>
<td>States may employ a consumer-directed service delivery model to provide PCS under the personal care optional benefit to individuals in need of personal assistance who have the ability and desire to manage their own care.</td>
</tr>
<tr>
<td><strong>Support system</strong></td>
<td>States must provide participating individuals with a support system that includes adequate assessment and counseling prior to enrollment, and throughout enrollment at the participant’s request. The support system is to also ensure that participants are able to manage their budgets.</td>
<td>For Section 1115 demonstrations and Section 1915(c) waivers that seek the IP designation, there must be a separate advocacy function available to participants who direct their services.</td>
<td>States may opt to employ several methods to ensure and monitor that individuals receive high quality PCS, e.g., use of criminal background checks for personal care providers, provide training to providers, etc. For individuals who cannot manage their own care, states may either provide PCS without self-direction or may permit family members or other individuals to direct the services on behalf of the individual.</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Section 6087 of the DRA (Self-Directed State Plan Option, Section 1915(j) of the Social Security Act)</td>
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<tr>
<td>Federal reporting requirements</td>
<td>States must provide the federal government with annual reports on the number of individuals served under this option and the total expenditures on their behalf in the aggregate.</td>
<td>Under the Section 1115 option, states report to CMS on quarterly and annual bases the following information: enrollment numbers, expenditure, quality assurance, and beneficiary survey findings. States must also submit a final report at the end of the demonstration period. Under the Section 1915(c) option, states follow the annual HCBS waiver protocol for reporting.</td>
<td>States must submit quarterly expenditure reports. The state plan must also provide that the Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records on each recipient and statistical, fiscal and other records necessary for reporting and accountability. States are also required to carry out a continuing quality control program, and to submit reports on reviews of claims on a monthly basis and a summary of findings on a 6-months basis and other reports as CMS requires.</td>
</tr>
<tr>
<td>Evaluation of impact</td>
<td>States must evaluate the overall impact of the program on the health and welfare of participants (as compared to non-participants) every three years.</td>
<td>N/A for 1915(c) waivers. 1115s include an evaluation requirement to determine the impact of the intervention.</td>
<td>N/A</td>
</tr>
<tr>
<td>Individualized budget plan</td>
<td>States must develop a written service plan and service budget for every participant.</td>
<td>The individualized budget decided by the planning process is controlled by the individual, and states must ensure that individuals understand how the budgets are calculated, how to adjust the budget, and the total dollar value of services.</td>
<td>N/A</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Section 6087 of the DRA (Self-Directed State Plan Option, Section 1915(j) of the Social Security Act)</td>
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</tr>
</tbody>
</table>
| Definition of self-direction | The participant exercises choice and control over the budget, planning, and purchase of self-directed PAS, including the amount, duration, scope, provider, and location of service provision. | Provides the opportunity for a participant to exercise choice and control in identifying, accessing and managing waiver services and other supports in accordance with their needs and personal preferences. The CMS requirements for a comprehensive IP, include:  
  • All waiver participants have the opportunity to elect to direct some or all of their waiver services.  
  • All participants live with their families, in their own private residence or in a living arrangement where services are furnished to fewer than four persons unrelated to the proprietor.  
  • The service planning process is participant-led and person-centered.  
  • Participant direction is available for most waiver services, including the services that are used most frequently by a significant number of waiver participants.  
  • Employer authority and budget authority are offered to all waiver participants who elect to direct waiver services.  
  • An appropriate method is used to determine the person-centered budget.  
  • There is a separate advocacy function available to participants who self-direct. | In states that choose to provide self directed PCS, the beneficiary may hire and train the provider, and supervise and direct the provision of the services and, if necessary, fire the provider. |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Individual participant</td>
<td>States can choose to give participants the ability to hire any individual capable of providing the assigned tasks, including legally liable relatives. Participants hire, fire, supervise, and manage the individuals providing services, and purchase PAS included in the budget.</td>
<td>Individuals may hire legally liable individuals to provide services.</td>
<td>States may employ a consumer-directed service delivery model to provide personal care services under the personal care optional benefit to individuals in need of personal assistance who have the ability and desire to manage their own care. Where an individual does not have the ability or desire to manage their own care, the state may either provide personal care services without consumer direction or may permit family members or other individuals to direct the provider on behalf of the individual receiving the services. Services must be provided by “qualified individuals”, and may not be provided by family members, defined as legally responsible relatives. Who is considered a “legally responsible relative” will vary according to state law. (from 42 CFR 440.167)</td>
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<td>responsibilities</td>
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<td>Allowed use of individual</td>
<td>States can choose to allow individuals to use their budgets for items that would increase independence or substitute for human assistance.</td>
<td>Under the Section 1115 option, individuals can purchase personal care and related services and supports and also items that substitute for human assistance or increase independence.</td>
<td>Under the Section 1915(c) option, individuals have the option to direct waiver services. They can also purchase goods and equipment.</td>
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<td>budgets</td>
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<tr>
<td>Characteristic</td>
<td>Section 6087 of the DRA (Self-Directed State Plan Option, Section 1915(j) of the Social Security Act)</td>
<td>Independence Plus (IP) demonstrations and waivers</td>
<td>Existing State Plan Personal Care Services (PCS) Option</td>
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<td>Financial management</td>
<td>States may use a financial management entity to make provider payments, track program costs, and make financial reports on the program.</td>
<td>Under the 1115 IP option, states can choose to allow individuals to receive cash to purchase services. Under the 1915(c) option, payment must be made through the Medicaid agency or another eligible entity. Individuals cannot receive cash.</td>
<td>N/A</td>
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<td>Definition of personal care</td>
<td>Under Section 6087 of the DRA, “the term ‘self directed personal assistance services’ means personal care and related services, or home- and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing the services.”</td>
<td>1115 waivers do not change the definition of services covered through the state plan or through a 1915(c) HCBS waiver.</td>
<td>Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual’s family; and (3) Furnished in a home, and at the State’s option, in another location. (b) For purposes of this section, family member means a legally responsible relative. [42 FR 47902, Sept. 11, 1997]</td>
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<tr>
<td>Characteristic</td>
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<td>Cost-neutrality</td>
<td>Section 6087 does not include requirements for cost-neutrality or budget-neutrality.</td>
<td>For the Section 1115 IP waiver, the program cannot cost more than the Federal government would have spent on the services without the waiver (i.e. budget-neutrality). For the 1915(c) waiver, average per capita expenditures under the waiver cannot exceed 100% of the average per capita expenditures that would have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/MR under the state plan, had the waiver not been granted (i.e., cost-neutrality).</td>
<td>Consumer-directed state plan PCS do not have to meet budget-neutrality or cost-neutrality requirements.</td>
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