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Medicaid Coverage of Long-Term Services and Supports

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Medicaid Coverage of Long-Term Services and Supports

Long-term services and supports (LTSS) refer to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to a physical, cognitive, or mental disability or condition. Often the individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time. Medicaid plays a key role in covering LTSS to aged and disabled individuals. As the largest single payer of LTSS in the United States, federal and state Medicaid spending accounted for \$200.1 billion or 42.1% of all LTSS expenditures in CY2020 (\$475.1 billion). LTSS are also a substantial portion of spending within the Medicaid program relative to the population served. In CY2020, LTSS accounted for 34.1% of all Medicaid spending. Of the 88.0 million total enrolled Medicaid population, an estimated 8.8 million (or 10.3%) received LTSS in CY2019 (the most recent year for which data are available).

Medicaid funds LTSS for eligible beneficiaries in both institutional and home and community-based settings, though the portfolio of services offered differs substantially by state. Moreover, states are required to offer certain Medicaid institutional services to eligible beneficiaries, while the majority of Medicaid home and community-based services (HCBS) are optional for states. In recent decades, federal authority has expanded to assist states in increasing and diversifying their Medicaid LTSS coverage to include additional HCBS coverage and delivery options. As a result, the share of Medicaid LTSS spending for HCBS has almost quintupled over the past three decades, accounting for 12% of Medicaid LTSS spending in FY1989 and increasing to more than half (59%) of total Medicaid LTSS spending in FY2019.

States now have a broad range of coverage options to select from when designing their LTSS programs. In general, Medicaid law provides states with two broad authorities, which either cover certain LTSS as a benefit under the Medicaid state plan or cover HCBS through a waiver program that permits states to disregard certain Medicaid requirements in the provision of these services, subject to approval by the Secretary of Health and Human Services (HHS). Over time, Congress has provided state Medicaid programs with additional state plan authority as well as federal payment incentives to expand their HCBS offerings. For example, the Deficit Reduction Act (DRA; P.L. 109-171) established HCBS as a state plan optional benefit under Section 1915(i) of the Social Security Act (SSA) and self-directed personal attendant services under SSA Section 1915(j). The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) amended the Section 1915(i) HCBS state plan option to provide state's further flexibility to enhance or expand their HCBS delivery systems. It also established a new HCBS state plan authority under SSA Section 1915(k) Community First Choice (CFC). The American Rescue Plan Act (ARPA; P.L. 117-2) includes a temporary 10-percentage-point increase to the federal medical assistance percentage (FMAP) for certain HCBS for states that meet the HCBS program requirements during the program improvement period (i.e., April 1, 2021, through March 31, 2022). States will be able to use available ARPA funds through March 31, 2025. Given the range of available coverage options, states continue to enhance or expand their LTSS delivery systems to cover additional services or target services to specific populations with a focus on HCBS.

This report provides a description of the various statutory authorities that either require or otherwise allow states to cover LTSS under Medicaid. See **Appendix A** for state information about coverage of Medicaid state plan optional benefits and **Appendix B** for data on HCBS and institutional Medicaid LTSS expenditures by service category.

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Introduction

Long-term services and supports (LTSS) refer to the array of institutional services (i.e. nursing facilities and intermediate care facilities) and home and community-based services (HCBS) provided to frail older adults and young adults with physical, intellectual, or developmental disabilities who require health-related services and hands-on assistance or supervision over an extended period of time. Medicaid plays a key role in covering LTSS to eligible aged and disabled individuals. As the largest single payer of LTSS in the United States, Medicaid LTSS spending (federal and state) in CY2020 totaled \$200.1 billion and accounted for 42.1% of all LTSS expenditures (\$475.1 billion).¹ LTSS are also a substantial portion of spending within the Medicaid program relative to the proportion of the Medicaid population served. In CY2020, Medicaid LTSS accounted for 34.1% of all Medicaid spending.² In contrast, 10.3% of Medicaid beneficiaries (8.8 million) used LTSS nationally in CY2019 (the most recent year for which data are available).³ Of these, 1.6 million beneficiaries (18.4%) received institutional services, 7.5 million (85.0%) received HCBS, and 0.3 million (3.5%) received both.⁴

Established under Title XIX of the Social Security Act (SSA), Medicaid is a means-tested individual entitlement program that finances the delivery of health care and LTSS to certain low-income individuals. The federal government and the states jointly finance the Medicaid program. States have primary responsibility for administering their Medicaid program within broad federal guidelines.⁵ The federal share of Medicaid service costs is determined by the federal medical assistance percentage (FMAP). FMAP rates are based on a formula that provides higher federal reimbursement to states with lower per capita income relative to the national average (and vice versa).⁶ Historically, to qualify for Medicaid, individuals must meet certain categorical and financial eligibility requirements.⁷ To qualify for Medicaid-covered LTSS, individuals must also meet needs-based eligibility criteria; that is, they have to demonstrate an extended need for long-term care. In general, needs-based criteria are state-defined and often measure functional need, such as an individual's ability to perform certain self-care activities and/or clinical need for care such as a diagnosis of chronic illness or disabling condition.

This report provides an overview of Medicaid coverage of LTSS, including the various statutory authorities that either require or otherwise allow states to cover LTSS under Medicaid. **Appendix A** provides state information about coverage of Medicaid state plan optional LTSS benefits, and

¹ CRS estimates based on National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2021. For further information on LTSS financing, see CRS In Focus IF10343, *Who Pays for Long-Term Services and Supports?*.

² Ibid. CRS estimates based on National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December 2021.

³ Kim, Min-Young, Edward Weizenegger, and Andrea Wysocki, *Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019*, Mathematica, July 22, 2022, <https://www.medicicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf>.

⁴ Ibid. Total U.S. counts include 48 states and DC. Alabama, Kentucky, and Vermont were excluded because these states had reporting errors for the Health Homes program.

⁵ For more information on Medicaid, see CRS Report R43357, *Medicaid: An Overview*.

⁶ For further information, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

⁷ For further information, see CRS Report R46111, *Medicaid Eligibility: Older Adults and Individuals with Disabilities*.

Appendix B provides data on HCBS and institutional Medicaid LTSS expenditures by service category.

Overview of Medicaid LTSS

Medicaid law and other SSA provisions contain several statutory authorities that permit states to offer LTSS to individuals in need of such services. In general, Medicaid law provides states with two broad authorities:

1. Medicaid state plan coverage, which is the agreement between a state and the federal government that describes how that state will administer its Medicaid program.
2. Medicaid waiver program coverage, which permits states to waive certain Medicaid statutory requirements under the state plan to allow the provision of noninstitutional LTSS, referred to as HCBS.⁸

Eligible enrollees can receive services under both the Medicaid state plan and the expanded range of HCBS under a waiver program at the same time.

LTSS Coverage Under Medicaid State Plan Versus Medicaid Waiver Program

Medicaid State Plan Coverage

- States are required to cover certain state plan services (mandatory services) and may choose to cover other additional services (optional services).

Covering LTSS under the State Plan: For example, under the state plan agreement, states are required to cover (1) nursing facility services for individuals age 21+ and (2) home health services, while most Medicaid state plan HCBS (e.g., personal care) are optional services that states can choose to cover.

Medicaid Waiver Program Coverage

- Subject to terms and conditions of the waiver agreement and Secretary of Health and Human Services' approval, states may choose to cover certain HCBS under one or more waiver programs.

Covering LTSS Under a Waiver: For example, states use waiver authorities under the Social Security Act (SSA)—Section 1915(c) Home and Community-Based Waivers and Section 1115 Research and Demonstration Waivers.

In addition, state Medicaid LTSS delivery systems include the provision of services in two types of settings: (1) services provided in institutional settings, such as nursing facilities, referred to as institutional LTSS, and (2) HCBS provided in home and community-based settings.

Institutional Settings

Institutional settings are residential settings that provide care on an inpatient basis (i.e., individual stays in the setting while receiving health care or LTSS). Medicaid-covered institutional care is provided in the following types of institutional settings: hospitals, long-term care facilities (LTCFs) or nursing homes, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), psychiatric hospitals, and Psychiatric Residential Treatment Facilities

⁸ As an alternative to states providing all of the mandatory and selected optional state plan benefits under “traditional” Medicaid, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established benchmark and benchmark-equivalent coverage, now referred to as “alternative benefit plans” (ABPs). In general, these benefit packages look more like benefit coverage available in the private market. However, in designing a Medicaid ABP, states may also choose to offer LTSS. For further information, see CRS Report R45412, *Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions*.

(PRTFs). Other terms, such as Institutions for Mental Diseases (IMDs), refer to coverage for Medicaid services by certain providers rather than a specific type of institutional provider or setting and has meaning only within the context of the Medicaid program.⁹ That is, IMDs are not identified as a provider type or setting by other payers, state licensing agencies, and health care accrediting organizations.

Medicaid-covered institutional LTSS are typically provided in LTCFs and ICFs/IID; however, mental health facilities are included in the Centers for Medicaid & Medicare Services (CMS) LTSS expenditure reports and analysis. For this reason, this report includes some discussion of Medicaid-coverage of institutional services in mental health facilities. Medicaid enrollee eligibility for institutional LTSS is generally tied to the need for institutional care referred to as level-of-care criteria, as defined by the state.

Medicaid institutional coverage assumes total care of the individual and provides comprehensive coverage, including the cost of room and board as well as the cost of covered services.¹⁰ In general, payment to the provider is a single bundled rate. However, states vary in what is included in the institutional rate versus what is billed as a separately covered service. Institutions must be licensed and certified by the state (in accordance with federal standards) and are subject to periodic oversight surveys, among other criteria.¹¹

Home and Community-Based Settings

Home and community-based settings are settings that deliver a range of health and social services to an individual residing in either a private home or in a group or congregate setting referred to as a community-based residential setting (see the text box “What are Home and Community-Based Services?”). Home and community-based settings also include nonresidential settings such as adult day health programs and settings that offer prevocational and educational or employment-based training and services.

Community-based residential settings provide housing and meals (i.e., room and board) as well as health care and social services and are referred to by a variety of names (e.g., board and care homes, adult foster care, personal care homes, group homes, and supported living arrangements, among others). Generally, these settings are licensed, registered, certified, or otherwise regulated by a state. However, whether they are licensed as a health care setting, long-term care setting, or congregate care setting can vary by state and resident population (i.e., physical disability, intellectual disability, behavioral health or Substance Use Disorder [SUD], aged 65 and older).

Home and community-based settings that seek Medicaid reimbursement for Medicaid-covered LTSS and other services must meet state-based Medicaid provider requirements. Alternatively, settings may contract with qualified providers to offer Medicaid-covered LTSS to eligible participants. Settings that seek Medicaid reimbursement specifically for home health services also must meet federal home health agency requirements.

⁹ Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to Congress on Oversight of Institutions for Mental Diseases*, January 2020, p. xii, <https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf>.

¹⁰ CMS, “Institutional Long Term Care,” <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/index.html>.

¹¹ CMS has oversight responsibilities over Medicaid- and Medicare-certified providers, but compliance surveys are generally conducted by State Survey Agencies. See CRS In Focus IF11545, *Overview of Federally Certified Long-Term Care Facilities* for more information on federal certification of long-term care facilities such as nursing homes. Statute allows a subset of providers, including hospitals, to be exempt from routine surveys by State Survey Agencies if they are accredited by an approved national accreditation organization.

What Are Home and Community-Based Services?

Home and community-based services (HCBS) refer to a category of care that includes various types of services that are provided to an individual for medical and other health-related purposes, as well as social services and supports that assist with daily living and the ability to live independently in the community. Collectively, these types of services are provided to individuals who generally have extended care needs and require long-term services and supports (LTSS). However, HCBS can also include services that are short-term or rehabilitative, often referred to as post-acute care. HCBS can also include certain mental/behavioral health services and Substance Use Disorder (SUD) services. For example, certain Medicaid HCBS authorities can cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. Various types of HCBS include, but are not limited to the following:

- Adult Day Health
- Assistive Technology Devices and Services
- Case Management
- Caregiver Services and Supports
- Employment Services and Supports
- Financial Management and Legal Services
- Habilitation
- Health Promotion and Disease Prevention
- Home Health
- Homemaker or Chore Services
- Home Modifications
- Housing-Related Assistance and Supports
- Personal Assistance
- Rehabilitation
- Respite
- Nutrition Services
- School-Based Services
- Transportation Services

Sometimes the terms *home care*, *home-based care*, and *home health* are used interchangeably to refer to HCBS. However, these terms may not always share the same meaning as the term HCBS. For example, *home care* may refer to the full range of health care that can be provided to individuals in a private home or residential setting, which may include acute and primary care services. These services may be delivered in-person or through the use of technology, including telehealth services. Such *home care* services may not be for a post-acute or LTSS need. The term *home health* is often used to refer to a specific type of benefit covered separately and distinctly under Medicaid and Medicare and is often included under the broader HCBS category.

There is no definition of HCBS under federal Medicaid law (Title XIX of the Social Security Act [SSA]). Section 9817 of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) defines HCBS in the provision of a temporary 10-percentage-point increase to the FMAP rate for certain Medicaid-covered HCBS. Specifically, this section defines HCBS to mean any of the following service categories authorized under SSA Title XIX: home health care; personal care; Program for All-Inclusive Care of the Elderly (PACE) services; HCBS authorized under subsections (b), (c), (i), (j), and (k) of SSA Section 1915; case management; rehabilitative services; and such other services specified by the Secretary of Health and Human Services (HHS); see CMS implementing guidance at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>.

Federal Medicaid reimbursement is provided to states only for the services provided in home and community-based settings (e.g., home health, personal care assistance, and homemaker or chore services). The Medicaid program does not provide federal reimbursement for the cost of housing, such as a monthly rent or mortgage payment. Specifically, federal Medicaid law prohibits federal reimbursement for the costs of room and board in community-based residential care settings.¹² State Medicaid programs may choose to offer other types of housing-related services and supports as a covered benefit and receive a federal match for doing so, including services to assist individuals with finding stable housing, transitioning from institutional to community living, and home adaptations or modifications to ensure housing is accessible to individuals with disabilities.¹³

¹² SSA 1915(c)(1) [42 U.S.C. 1396n].

¹³ For more information, see CMS guidance at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>.

To receive federal Medicaid reimbursement, states must ensure that HCBS provided under certain statutory authorities are delivered in home and community-based settings that meet certain requirements, such as being integrated in the community, offering residents a choice among settings, ensuring residents' rights and personal independence, and offering a choice of services or providers. Provider-owned or controlled settings also must meet the following conditions: tenancy agreements, residents' privacy within their units, residents' ability to control their own schedules and visitor access, and physical accessibility.

Effective March 17, 2014, the HCBS settings rule requires states to develop a process, approved by CMS, to transition their current programs into compliance. Initially, states had a five-year period to transition (i.e., through March 17, 2019); however, CMS subsequently extended the transition period to allow states an additional three years, through March 17, 2022, to demonstrate compliance. Due to the impact of the COVID-19 pandemic, CMS has further extended the timeframe for states to complete the requirement implementation of activities and has provided states an additional year, through March 17, 2023, to demonstrate compliance with the settings requirements.¹⁴

Medicaid LTSS Coverage

Federal law requires that state Medicaid programs cover certain LTSS for eligible participants, such as nursing facility care for adults. However, states have a range of options that allow LTSS coverage of certain institutional and noninstitutional LTSS, including HCBS for eligible participants based on need. These options often allow states to target coverage to specific groups of individuals. For example, states often tailor LTSS coverage to older adults, younger adults, or children with physical, intellectual, or developmental disabilities, or adults receiving behavioral health services, among other populations. These flexibilities under Medicaid law have led to widespread variation in state Medicaid LTSS benefit packages.

One important issue for Medicaid LTSS coverage is its perceived bias in favor of institutional care. The original 1965 Medicaid law established that eligible Medicaid beneficiaries are entitled to nursing facility care. However, increasing expenditures for institutional care and growing public demand for community-based alternatives have spurred federal policymakers to assist states in increasing and diversifying their Medicaid LTSS coverage to include optional HCBS, often referred to as “rebalancing.”¹⁵

Over time, Congress has provided state Medicaid programs with additional authority as well as federal payment incentives to expand their HCBS offerings. For example, Section 9817 of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) includes a temporary 10-percentage-point increase to the FMAP rate for certain HCBS for those states that meet the HCBS program

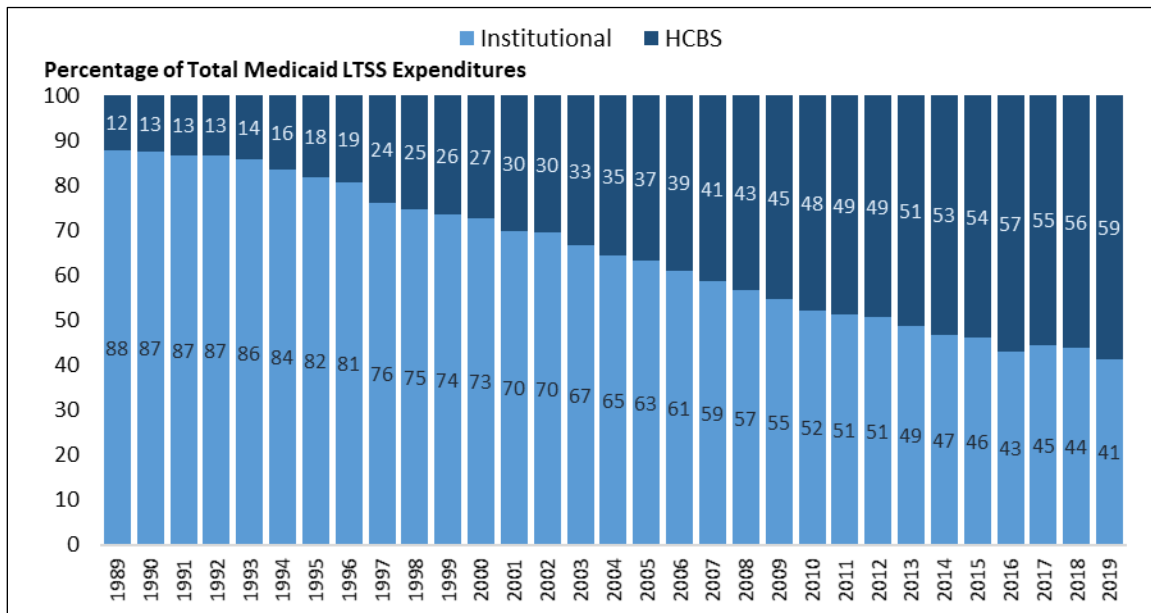
¹⁴ CMS established requirements for home and community-based settings in Medicaid HCBS programs and aligns these requirements across three Medicaid authorities under the Social Security Act (SSA)—Section 1915(c) HCBS waivers, Section 1915(i) HCBS state plan option, and Section 1915(k) Community First Choice (CFC) state plan option; Department of Health and Human Services, “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule,” 79 *Federal Register* 2948-3039, January 16, 2014. For more information, see CMS, SMD # 20-003, *Home and Community-Based Settings Regulation – Implementation Timeline Extension and Revised Frequently Asked Questions*, July 14, 2020), and CMS, “Home & Community Based Services Final Regulation,” at <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>.

¹⁵ CMS, *Long-Term Services and Supports Rebalancing Toolkit*, November 2020, <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>.

requirements during the program improvement period (i.e., April 1, 2021 through March 31, 2022). States will be able to use available ARPA funds through March 31, 2025.¹⁶

In addition, these legislative and administrative activities to expand Medicaid HCBS were prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,¹⁷ which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). Thus, states have a broad range of coverage options under current law to select from when designing their LTSS programs. As a result, the share of Medicaid LTSS spending for HCBS has increased over the past three decades, from 12% of Medicaid LTSS spending in FY1989 to more than half (59%) of total Medicaid LTSS spending in FY2019 (see **Figure 1**).¹⁸

Figure 1. Medicaid Home and Community-Based Services (HCBS) and Institutional LTSS Expenditures as a Percentage of Total Medicaid LTSS Expenditures (FY1989 to FY2019)



Source: Caitlin Murray et al., *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019*, Mathematica Policy Research, December 9, 2021, at <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>.

LTSS State Plan Coverage

The state plan is the agreement between a state and the federal government that describes how that state administers its Medicaid program and provides assurance that the state will meet federal

¹⁶ CMS, “Updated Reporting Requirements and Extension of Deadline to Fully Expend State Funds Under American Rescue Plan Act of 2021 Section 9817,” SMD# 22-002, June 3, 2022, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22002.pdf>.

¹⁷ 527 U.S. 581 (1999).

¹⁸ Caitlin Murray, Alena Tourtellotte, et al., *Medicaid Long-Term Services and Supports Annual Expenditures Report, Federal Fiscal Year 2019*; Mathematica Policy Research, December 9, 2021, at <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>.

Medicaid requirements in order to receive federal Medicaid funds for program activities. In general, the Medicaid state plan describes the specific eligibility groups or populations of individuals covered; the amount, duration, and scope of benefits to be provided, including any optional benefits a state may choose to cover; methodologies for providers to be reimbursed; and any administrative requirements that states must meet in order to participate.¹⁹ State plans are developed by the states and approved by CMS. States may update their state plans by submitting a state plan amendment (SPA) for CMS review and approval. Once a state plan or SPA is approved, states may receive federal Medicaid funds for covered benefits without further need for CMS review or approval.

Medicaid statutory provisions require states to cover certain benefits under the “traditional” Medicaid state plan program (i.e., mandatory benefits) and give states the option to cover others (i.e., optional benefits). Among the mandatory and optional Medicaid state plan LTSS benefits described in **Table 1**, the only benefits that participating states are required by federal law to cover are nursing facility services for beneficiaries aged 21 and older and home health services. States must offer these services to all enrollees across the state as determined by medical necessity. However, each state determines the amount, duration, and scope of these services.

States may choose to cover other optional LTSS benefits (institutional and HCBS) under the Medicaid state plan. States also have authority to cover packages of HCBS targeted at particular groups of beneficiaries. Similar to mandatory state plan benefits, each state determines the amount, duration, and scope of these services. With respect to state plan services, federal law requires states to meet the following guidelines, with some exceptions:

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

Table 1 lists the LTSS state plan services by provider setting (institutional versus HCBS) and by type (mandatory or optional).²⁰ With respect to the HCBS benefits identified in **Table 1**, the optional state plan benefits may either be a stand-alone benefit (e.g., case management, personal care services) or reflect a package of HCBS benefits determined by the state that are provided under a specific statutory authority (e.g., State Plan HCBS Optional, Community First Choice).

¹⁹ CMS, *Medicaid State Plan Amendments*, at <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html>.

²⁰ This report includes those Medicaid LTSS service categories identified in Caitlin Murray, Alena Tourtellotte, et al., *Medicaid Long Term Services and Supports Annual Expenditures Report Federal Fiscal Year 2019*, Mathematica, December 9, 2021. This report does not include discussion of SSA Section 1929, which authorizes states to provide HCBS for functionally disabled elderly individuals. According to the Kaiser Family Foundation, Texas is the only state that uses this statutory authority (see Sowers, M., H. Claypool, and M. Musumeci, *Streamlining Medicaid Home and Community-Based Services: Key Policy Questions*, Kaiser Family Foundation, March 2016, <http://files.kff.org/attachment/issue-brief-streamlining-medicaid-home-and-community-based-services-key-policy-questions>). In addition, this report does not include discussion of the Medicaid Money Follows the Person Rebalancing Demonstration Program. For more information, see CRS In Focus IF11839, *Medicaid’s Money Follows the Person Rebalancing Demonstration Program*.

These HCBS benefits packages may include services that are similar to those covered under Medicaid waiver authorities such as the SSA Section 1915(c) HCBS waiver program, which allows states additional flexibility to cover other specified HCBS, subject to HHS Secretary approval (see the “Medicaid HCBS Waiver Programs” and “Key Features of Selected Coverage of HCBS Under Medicaid” sections for more information).

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

	Mandatory Benefits	Optional Benefits
Institutional Services	Nursing Facility Services (age 21 and older) [SSA §1902(a)(10)(A) and §1905(a)(4)]	Nursing Facility Services (under age 21) [SSA §1905(a)(30)]
		Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) [SSA §1905(a)(15)] ^a
		Services in Institutions for Mental Diseases (IMDs) (age 65 and older) [SSA §1905(a)(14)]
		Inpatient Psychiatric Care (under age 21) [SSA §1905(a)(16)]
		Private Duty Nursing Services [SSA §1905(a)(8)]
Home & Community-Based Services	Home Health Services [SSA §1902(a)(10)(D) and §1905(a)(7)]	Case Management/Targeted Case Management [SSA §1905(a)(19)]
		Health Homes [SSA §1945]
		Personal Care Services [SSA §1905(a)(24)]
		Private Duty Nursing Services [SSA §1905(a)(8)]
		Program of All-Inclusive Care for the Elderly (PACE) [SSA §1905(a)(26)]
		Rehabilitative Services [SSA §1905(a)(13)]
		State Plan Home and Community-Based Services (HCBS) [SSA §1915(i)]
		Self-Directed Personal Assistance Services (PAS) [SSA §1915(j)]
		Community First Choice (CFC) [SSA §1915(k)]

Sources: CRS. For the full-range of Medicaid state plan mandatory and optional benefits, see the Centers for Medicare & Medicaid Services website at <https://www.medicare.gov/medicaid/benefits/mandatory-optional-medicare-benefits/index.html>.

- a. Federal Medicaid law uses the term “intermediate care facilities for the mentally retarded” and the abbreviation “ICFs/MR”; however, federal agencies use the term “intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).”

The following describes these coverage options in greater detail. For state-specific information about certain selected optional benefits included in **Table 1**, see **Table A-1**.

Institutional Services

Under Medicaid statute, “institutional services” refer to specific benefits authorized in the SSA, including hospital services, nursing facility services, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and inpatient psychiatric services for individuals under age 21, which may be provided in hospital settings or psychiatric residential treatment facilities (PRTFs) and institutions for mental diseases (IMDs).

Mandatory Institutional State Plan Services

The original 1965 Medicaid law established nursing facility care as a mandatory Medicaid LTSS benefit for adults aged 21 and over. Even though nursing facility institutional services are mandatory for enrollees who meet their state’s financial and needs-based eligibility criteria, states can define amount, duration, and scope of services within broad federal guidelines, so coverage varies by state.

Nursing Facility Services

States are required to cover nursing facility services for beneficiaries aged 21 and over under their Medicaid plans.²¹ States have the option to cover nursing facility services for beneficiaries under age 21.²² According to CMS, all states provide this optional service.²³ Beneficiaries must also meet state-defined nursing home eligibility criteria, often referred to as *level-of-care criteria*. Nursing facility services include nursing care and related services, dietary services, physician services, specialized rehabilitation services (e.g., physical and occupational therapy, speech pathology and audiology services, and mental health rehabilitative services), emergency dental care, and pharmacy services.²⁴

Optional Institutional State Plan Services

Beyond the required coverage of nursing facility services, states have the option to cover additional institutional services such as services provided in ICFs/IID and institutional mental health services for certain populations under their Medicaid state plans. Even though these are optional services, states that offer them must follow federal minimum standards to receive federal Medicaid funding, but amount, duration, and scope can vary by state.

*Services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*²⁵

States may provide services to eligible Medicaid beneficiaries residing in ICFs/IID as an optional service under a state’s Medicaid plan. The primary purpose of the ICFs/IID is to furnish health or

²¹ SSA §1902(a)(10)(A) [42 U.S.C. 1396a(a)(10)(A)]; and SSA §1905(a)(4) [42 U.S.C. 1396d(a)(4)].

²² SSA §1905(a)(30) [42 U.S.C. 1396(a)(30)].

²³ CMS, “Nursing Facilities,” at <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/index.html>.

²⁴ 42 C.F.R. §§483.1-483.95.

²⁵ Federal Medicaid law uses the term “intermediate care facilities for the mentally retarded” and the abbreviation

rehabilitative services to persons with intellectual disabilities or other related conditions.²⁶ ICFs/IID must provide certain services including nursing, physician, dental, pharmacy, and laboratory services.²⁷ According to CMS, beneficiaries who receive services in an ICF/IID are likely to have other disabilities or conditions in addition to intellectual disabilities, such as seizure disorders, behavior issues, and/or mental illness.²⁸ Medicaid specifies that ICFs/IID must provide a program of “active treatment,” as defined by the Secretary of HHS. Federal regulations refer to “active treatment” as aggressive, consistent implementation of a program of generic and specialized training, treatment, and health services.²⁹ In 2018, 43 states and the District of Columbia (DC) reported covering services in an ICF/IID.³⁰

*Institutional Mental Health Services*³¹

Two Medicaid statutory authorities cover inpatient mental health services, each targeting a specific subset of individuals: (1) those individuals aged 65 and over, and (2) those individuals under age 21.³² Medicaid coverage of inpatient mental health services includes diagnosis and medical treatment, as well as nursing care and related services under the direction of a physician and covers services in specific types of facilities that are different for each of the following benefits:

- **Institutions for Mental Disease for Individuals Aged 65 years and Over.** States have the option to provide Medicaid coverage for inpatient mental health services delivered in hospitals or nursing facilities that are considered institutions for mental disease (IMD) to eligible beneficiaries aged 65 years and over.³³ In 2018, 41 states and DC reported covering services in IMDs to individuals aged 65 and over.³⁴
- **Inpatient Psychiatric Care for Enrollees Under Age 21.** States have the option to provide inpatient psychiatric hospital services in a psychiatric hospital, a psychiatric unit in a hospital, or a psychiatric residential treatment facility for individuals under age 21.³⁵ This is commonly referred to as the “Psych Under 21”

“ICFs/MR”; however, federal agencies use the term “intermediate care facilities for individuals with intellectual disabilities” and the abbreviation ICFs/IID, which is the term and abbreviation used in this report.

²⁶ SSA §1905(d) [42 U.S.C. §1396d(d)].

²⁷ 42 C.F.R. §483.460.

²⁸ CMS, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*, at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/ICFIID>.

²⁹ 42 C.F.R. §483.440.

³⁰ Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities, 2018,” at <https://www.kff.org/medicaid/state-indicator/intermediate-care-facility-services>.

³¹ This section of the report was authored by Alison Mitchell, CRS Specialist in Health Care Financing.

³² The Medicaid institutions for mental disease (IMD) exclusion rule prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals aged 21 through 64 who are patients in IMDs. For more information, see CRS In Focus IF10222, *Medicaid’s Institutions for Mental Disease (IMD) Exclusion*.

³³ SSA §1905(a)(14) [42 U.S.C. §1396d(a)(14)].

³⁴ Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Services in Institutions for Mental Disease, Age 65 and Older, 2018” at <https://www.kff.org/medicaid/state-indicator/services-in-institutions-for-mental-disease-age-65-and-older/>.

³⁵ SSA §1905(a)(16) and (h) [42 U.S.C. 1396d(a)(16) and (h)]; 42 C.F.R. §441.151.

benefit. For states that do not offer the Psych Under 21 benefit, a determination of medical necessity under Medicaid’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit would require the state pay for inpatient psychiatric services that are provided in these settings.³⁶ State reported data regarding Psych Under 21 coverage is not available.

Private Duty Nursing

States may offer private duty nursing services to beneficiaries who require greater individual and continuous care than what is routinely provided by the nursing staff in a hospital or nursing facility.³⁷ When private duty nursing is provided in institutional settings, the benefit does not include room and board. Private duty nursing can also be provided in community-based settings (see the “Optional State Plan HCBS” section below). Private duty nursing is intensive skilled nursing care and may cover situations where an individual’s health care needs require extended care, including 24-hour-a-day coverage. For example, a beneficiary may be technology-dependent and rely on medical interventions such as mechanical ventilation, tube feedings, or intravenous medications. These skilled nursing services are provided by a registered nurse or a licensed practical nurse under the direction of the beneficiary’s physician. In 2020, 31 states reported covering *any* private duty nursing services.³⁸

Home and Community-Based Services (HCBS)

HCBS refer to a category of various types of LTSS that are delivered in private homes and community settings, such as adult day health centers, assisted living facilities, and similar types of community-based residential settings, as opposed to institutional settings, such as hospitals or nursing homes. HCBS includes *health services* that are provided for medical and other health-related purposes, as well as *social services and supports* that assist individuals with activities of daily living and provide support for independent living in the community. This section of the report focuses on Medicaid coverage of HCBS that are provided to individuals who have a need for LTSS.

Mandatory State Plan HCBS

Home health is the only mandatory HCBS benefit under a Medicaid state plan. States must provide the home health benefit for enrollees who meet their state’s financial and needs-based

³⁶ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a broad Medicaid pediatric benefit available to most enrollees under age 21. EPSDT encompasses periodic screenings (comprehensive child health assessments, including physical examinations, preventive dental services, vision and hearing testing, appropriate immunizations, and laboratory tests), certain interperiodic screenings, diagnosis, and treatment. States are required to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions identified during a health care screening. EPSDT services may cover certain LTSS that are medically necessary for children and young adults under the age of 21. For more information on EPSDT, see CMS, “Early and Periodic Screening, Diagnostic, and Treatment,” at <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>.

³⁷ 42 C.F.R. §440.80.

³⁸ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table7>. This data do not distinguish whether the private duty nursing service was offered in an institutional or community-based setting.

eligibility criteria, but states can define amount, duration, and scope of services within broad federal guidelines, so coverage varies by state.

Home Health Services

Home health services are a mandatory benefit linked to requirements that states provide nursing facility coverage for certain individuals.³⁹ States must cover home health services for categorically eligible individuals *aged 21 and older* who are *entitled* to nursing facility coverage under a state’s Medicaid state plan.^{40,41} States must also offer home health to categorically eligible individuals *under age 21* if the state plan provides nursing facility services to this population group. Medicaid eligibility for the home health services benefit is not conditional on a need for institutional care or the need for skilled nursing or therapy services. Further, Medicaid home health services are not limited to beneficiaries who are homebound, nor are they required to be furnished in the place of residence, with certain exceptions.⁴²

At a minimum, the home health service benefit includes nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for in-home use.⁴³ States have the flexibility to offer additional therapeutic services under the home health benefit, such as physical therapy, occupational therapy, speech pathology, and audiology services. In 2018, most states reported expanding the scope of their mandatory home health benefit to include these optional therapies.⁴⁴ Once the home health benefit is determined, states must offer both the required and optional home health services to all Medicaid beneficiaries entitled to nursing facility services under their state plans. Home health services must be ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant as part of a written plan of care and reviewed by the physician every 60 days.

³⁹ For more information, see U.S. Department of Health and Human Services, *Understanding Home and Community-Based Services: A Primer*, 2010, <http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm>.

⁴⁰ In general, there are two broad classifications of Medicaid eligibility groups: (1) categorically needy (which include both mandatory and optional eligibility groups) and (2) medically needy (optional eligibility group). Historically, Medicaid eligibility was subject to categorical restrictions that generally limited coverage to certain categories of individuals (i.e., “categorically needy”) such as the elderly, persons with disabilities, or members of families with dependent children. States may choose to cover the “medically needy” who are individuals with income too high to qualify as categorically needy. Medically needy coverage is particularly important for the elderly and persons with disabilities, since this pathway allows deductions for medical expenses that lower the amount of income counted in the determination of financial eligibility for Medicaid.

⁴¹ Individuals who are eligible for nursing facility services are not necessarily entitled to such care. To be entitled to nursing facility services, eligible individuals must also meet state-based nursing facility eligibility criteria or institutional level-of-care criteria. Federal regulations specify coverage groups entitled to home health as (1) categorically eligible individuals aged 21 or over; (2) categorically eligible individuals under age 21 if the state plan provides nursing facility services to this population group; and (3) medically needy individuals to whom nursing facility services are provided under the state plan (42 C.F.R. §441.15).

⁴² See 42 C.F.R. §440.70(c)(1).

⁴³ See 42 C.F.R. §440.70.

⁴⁴ In 2018, 44 states covered these optional services, 2 states (Alabama and Oklahoma) do not, and 5 states did not report; see Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Home Health Services – Physical Therapy, Occupational Therapy, and/or Speech Pathology/Audiology, 2018,” at <https://www.kff.org/other/state-indicator/medicaid-benefits-home-health-services-including-physical-therapy-occupational-therapy-and-or-speech-pathology-audiology>.

Optional State Plan HCBS

Beyond the required coverage of home health services, states have the option to cover additional HCBS under their Medicaid state plan. Even though these are optional services, states that offer them must follow federal minimum standards to receive a federal Medicaid funding, but amount, duration, and scope can vary by state.

Case Management/Targeted Case Management

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

States choosing to offer the case management benefit must make it available on a statewide basis. States also have the option to offer a targeted case management benefit to a specified beneficiary population within a specific geographic area. As with the case management benefit, states can use targeted case management to help such individuals gain access to needed medical, social, educational, and other services. To be eligible for either benefit option, Medicaid beneficiaries must meet the state-defined eligibility criteria for that benefit. In FY2020, 30 states reported covering case management services.⁴⁵

Health Homes

States may establish and offer health homes, which integrate physical and behavior health services with LTSS for Medicaid beneficiaries with complex care needs, as an optional Medicaid state plan benefit.⁴⁶ The health home benefit includes six core services, which are listed in federal statute and are defined by the state. These six core services are comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; individual and family support; and referral to community and social support services.⁴⁷ States determine the type of providers that can deliver the health home benefit (i.e., physicians, rural health clinics, teams of health professionals, etc.) within certain federally determined parameters.

To qualify for the health home benefit, a Medicaid beneficiary must have at least two chronic conditions, or have one chronic condition and be at risk for another, or have one serious and persistent mental health condition.⁴⁸ Qualifying chronic conditions include a mental health condition, substance use disorder, asthma, diabetes, heart disease, being overweight, or other

⁴⁵ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table8>.

⁴⁶ SSA §1945 [42 U.S.C. §1396w-4].

⁴⁷ CMS, "Medicaid Health Homes: An Overview," Fact Sheet, April 2021, at [medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf](https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf).

⁴⁸ SSA §1945 [42 U.S.C. §1396w-4(h)(1)(A)].

conditions as allowed by the HHS Secretary.⁴⁹ States can target the health home benefit to Medicaid beneficiaries with certain qualifying medical conditions and also geographically; however, they must offer the benefit to all categorically needy individuals that meet the state's eligibility criteria and without consideration to age.⁵⁰ In 2018, 22 states and DC reported offering health homes as a covered service.⁵¹

Personal Care Services

States may offer personal care services as an optional Medicaid state plan benefit. These services enable older individuals and persons with disabilities or chronic conditions to accomplish certain activities they would otherwise not be able to accomplish independently.⁵² Personal care services include assistance with performing activities of daily living (ADLs), such as eating, bathing, dressing, toileting, and transferring (from a bed to a chair, etc.). Services may also include assistance with instrumental activities of daily living (IADLs), which facilitate independent living in the community, such as providing light housework, laundry, meal preparation, transportation, and grocery shopping. Assistance may be in the form of hands-on assistance (i.e., actually performing a task for an individual) or prompting an individual to perform the task by himself or herself. For individuals with cognitive impairments, such assistance may also include supervising or prompting an individual to perform the task.

States choosing to offer the personal care services benefit must make it available on a statewide basis. Personal care services must be authorized by a physician or, at state option, otherwise authorized under a state-approved plan of care. Services are furnished to individuals at home or, at state option, in other settings (such as a workplace or senior center). In general, services may not be provided to individuals who are inpatients or residents of hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), or psychiatric institutions.⁵³ Personal care services must be provided by a qualified provider and may be furnished by family members of the Medicaid participant, with the exception of legally responsible relatives (i.e., spouse or parent of minor children). Furthermore, the provision of personal care services may be directed by the beneficiary, including the beneficiary having the

⁴⁹ SSA §1945 [42 U.S.C. §1396w-4(h)(2)].

⁵⁰ CMS, at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

⁵¹ Health Homes refers to health homes as established by Section 2703 of the Affordable Care Act. Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: ACA Health Homes, 2018," at <https://www.kff.org/other/state-indicator/medicaid-benefits-aca-health-home/>.

⁵² As per SSA §1905(a)(24) [42 U.S.C. §1396d]; 42 C.F.R. §440.167; and Section 4480 of the State Medicaid Manual, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

⁵³ Section 3715 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) authorizes states to continue to provide HCBS to individuals in acute care hospitals. Such services must meet the needs of the individual that are not met through the provision of hospital services and are in addition to, and may not substitute for, the services the hospital is obligated to provide. HCBS provided must also be identified in the individuals' person-centered service plan and be designed to ensure smooth transitions between acute care settings and home and community-based settings and to preserve the individual's functional abilities. Additionally, states must describe the services provided by the HCBS provider or caregiver to avoid duplication of services, how the HCBS will assist the individual in returning to the community, and any differences in the typical billed rate for HCBS provided during hospitalization. For more information, see CRS Report R46334, *Selected Health Provisions in Title III of the CARES Act (P.L. 116-136)*, and CMS, *Covid-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* (last Updated January 6, 2021), at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-new-faqs.pdf>.

ability to hire, train, and supervise personal care attendants.⁵⁴ In FY2020, 36 states and DC reported covering personal care services.⁵⁵

Private Duty Nursing Services

States may offer private duty nursing services to eligible beneficiaries who require greater individual and continuous care than what is available from a visiting nurse under a home health benefit.⁵⁶ Similar to skilled nursing, private duty nursing is more intensive and may cover situations where an individual’s health care needs require extended care, including 24-hour-a-day coverage. For example, a beneficiary may be technology-dependent and rely on medical interventions such as mechanical ventilation, tube feedings, or intravenous medications. Private duty nursing can also be provided in institutional settings (see the “Optional Institutional State Plan Services” section above). Private duty nursing is intensive skilled nursing care provided by a registered nurse or a licensed practical nurse under the direction of the beneficiary’s physician. Such services can be provided to a beneficiary in a community-based setting, including outside of the home when a recipient’s normal life activities take the recipient into other community settings, such as school. However, the benefit is limited to Medicaid beneficiaries who need such services in the home.⁵⁷ In FY2020, 31 states reported covering *any* private duty nursing services.⁵⁸

Program for All-Inclusive Care for the Elderly (PACE)⁵⁹

The Program for All-Inclusive Care for the Elderly (PACE) is a federal-state program that provides eligible, frail elderly individuals with a community-based alternative to other LTSS delivery options.⁶⁰ Organizations that provide PACE, which are nonprofit as well as for-profit entities, integrate Medicare and Medicaid services and operate similarly to health maintenance organizations (HMOs). The PACE programs these organizations provide include a full range of social and medical home-and-community based services, for example adult day health, home health, and social services, as well as traditional acute care medical services.⁶¹ In FY2020, 33 states reported offering PACE as a covered service.⁶²

⁵⁴ SSA §1915(j) expands participant direction for personal care services for states offering such care under their Medicaid state plan or offering a SSA §1915(c) HCBS waiver program. See the “Self-Directed Personal Care Assistance” section below.

⁵⁵ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.

⁵⁶ 42 C.F.R. §440.80.

⁵⁷ CMS, Section 4310 of the State Medicaid Manual, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

⁵⁸ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table7>. This data do not distinguish whether the private duty nursing service was offered in an institutional or community-based setting.

⁵⁹ This section of the report was authored by Cliff Binder, CRS Analyst in Health Care Financing.

⁶⁰ States must amend their state Medicaid plans to provide PACE as an optional Medicaid benefit.

⁶¹ PACE Manual, Chapter 1—Introduction to PACE, 30.2 PACE Organizations.

⁶² Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at

To qualify for PACE programs, individuals must reside in a PACE center service area, be at least age 55, require nursing home levels of care as determined by state Medicaid programs, and at the time of enrollment be able to live safely in a community setting with PACE assistance.⁶³ Most PACE participants are eligible for both Medicare and Medicaid (dually eligible), but Medicare or Medicaid eligibility is not required to enroll in the PACE program.⁶⁴

PACE organizations, like HMOs, are paid a capped fixed monthly fee regardless of the care needed by PACE participants, including prescription drugs. PACE participants do not have deductibles, co-payments, or other cost sharing requirements.⁶⁵ PACE organizations receive capitated payments from Medicare as well as state Medicaid programs.⁶⁶ Generally, Medicare covers the acute care portion of PACE benefits, while Medicaid covers the LTSS and additional social support benefits. Individuals not covered by Medicare and/or Medicaid are financially responsible for the premiums for the program(s) for which they are ineligible.⁶⁷ Typically, PACE programs deliver most health and social services needed by PACE participants at community-based centers, most often adult day care centers. PACE organizations also are required to have contracts for ambulatory, inpatient, and specialty care providers to ensure that the full range of acute and long-term care that may be needed by PACE participants is available.⁶⁸

Rehabilitative Services

States can offer a distinct rehabilitative services benefit as a state plan option that provides individuals with services related to the rehabilitation of physical or mental health conditions. The rehabilitative services option is broadly defined as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.”⁶⁹ States choosing to offer this benefit must offer it on a statewide basis.

The rehabilitative services option can be provided in community settings, including in an individual’s home or work environment, and can be provided by professionals and paraprofessionals. There is no requirement that rehabilitative services be provided under a physician’s direction. This benefit option is distinct from rehabilitative services offered in institutional settings such as a Medicaid nursing facility or ICFs/IID. Services provided under the optional Medicaid rehabilitative benefit span a wide range of treatments. States may use the rehabilitative services benefit option to provide services to beneficiaries diagnosed with mental

<https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table10>.

⁶³ Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 4—Enrollment and Disenrollment, 10.2 Eligibility Criteria.

⁶⁴ In 2022, approximately 90% of PACE participants were dually eligible for Medicare and Medicaid. National PACE Association, PACE by the Numbers.

⁶⁵ PACE Manual, Chapter 1—Introduction to PACE, 30.3 Eligibility and Benefits.

⁶⁶ PACE Manual, Chapter 13—Payments to PACE Organizations, 10.1 General Payment Principles.

⁶⁷ PACE Manual, Chapter 1—Introduction to PACE, 30.4, Payments to PACE Organizations.

⁶⁸ The PACE model of care relies on an Interdisciplinary Team (IDT) composed of a required mix of specific types of health professionals. PACE Manual, Chapter 8 – IDT, Assessment & Care Planning, 10.1, IDT Composition.

⁶⁹ SSA §1905(a)(13) [42 U.S.C. §1396d(a)(13)].

health conditions or substance use disorders, and/or to provide beneficiaries with physical, occupational, and speech therapy. In FY2020, 24 states reported covering rehabilitative services.⁷⁰

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

Section 1915(i) of the SSA allows states to offer a broad range of HCBS under their Medicaid state plan. States that choose this optional benefit can cover HCBS for certain eligible Medicaid beneficiaries without obtaining a Secretary-approved waiver for this purpose. However, eligible beneficiaries must meet specific financial and needs-based eligibility criteria for the state plan HCBS Option. To be eligible for the Section 1915(i) benefit, Medicaid beneficiaries' incomes must

- be less than or equal to 150% of the federal poverty level (FPL, \$1,699 per month for an individual in 2022),⁷¹ and
- have a level-of-care need that is less than the level of care required in an institution, as defined by the state.

States may extend eligibility for the Section 1915(i) benefit to beneficiaries with incomes up to 300% of the Supplemental Security Income (SSI) federal benefit rate (\$2,523 per month for an individual in 2022)⁷² for those eligible for HCBS under home and community-based waiver programs.⁷³ For eligible beneficiaries who meet this higher financial eligibility threshold and waiver criteria, their level-of-care need may have to meet the level of care provided in an institution.⁷⁴

The HCBS state plan option allows states to tailor different benefit packages to certain groups of beneficiaries. States can make this option available to specific populations and can vary the benefit package, as well as the amount, duration, or scope of the benefits for each of these populations. When states target the state plan HCBS option to certain groups of beneficiaries, such state plan amendments are for five-year periods (i.e., an initial five-year period and subsequent five-year renewal periods).⁷⁵ States must offer benefit packages statewide and may not cap the number of beneficiaries receiving state plan HCBS. To help states manage enrollment, Medicaid law allows states to modify their needs-based eligibility criteria without obtaining prior approval from the HHS Secretary.

In the design of each benefit package, states may choose from the same list of services offered under a Section 1915(c) HCBS waiver program (see **Table 2** in the “Medicaid HCBS Waiver Programs” section for a general description of these services). The list includes services such as case management, home-maker/home health aide, personal care, adult day health, habilitation, and respite care. For individuals with chronic mental illness, states may provide day treatment,

⁷⁰ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table9>.

⁷¹ HHS, “Poverty Guidelines, HHS Poverty Guidelines for 2022,” at <https://aspe.hhs.gov/poverty-guidelines>.

⁷² SSA, “Fact Sheet: 2022 Social Security Changes,” at <https://www.ssa.gov/news/press/factsheets/colafacts2022.pdf>.

⁷³ Includes Medicaid waiver programs authorized under SSA §1115 or SSA §1915(c), (d) or (e).

⁷⁴ States may also create a new SSA §1915(i) eligibility pathway into Medicaid to increase access to HCBS for individuals who need a lower level of care than is provided in an institution. States may extend full Medicaid benefits to this new eligibility group.

⁷⁵ SSA §1915(i)(7)(B) [42 U.S.C. §1396n(i)(7)(B)].

other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). Similar to Section 1915(c) waivers, states have the ability to name and define Section 1915(i) services, as well as identify and define other services, subject to HHS Secretary approval. This flexibility has led to state variation in naming conventions and service definitions across HCBS state plan and waiver services.

In addition, states may seek HHS Secretary approval to offer other services, with the exception of room and board. Section 1915(i) services must be provided in a home and community-based setting.⁷⁶ In FY2020, 12 states and DC reported having a Section 1915(i) state plan HCBS option in place.⁷⁷

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

Section 1915(j) of the SSA authorizes states to provide self-directed personal care assistance services (PAS), which include personal care and related home and community-based services. States can provide self-directed options either under a state's Medicaid State plan, if personal care is an existing state plan benefit option, and/or an existing Section 1915(c) HCBS waiver. Participation in self-directed PAS is voluntary, and states may limit the number of individuals who self-direct. States are not required to provide self-directed PAS on a statewide basis and may target the benefit to particular geographic regions. States have the option to disburse cash prospectively to participants who direct their PAS. States also have the option to allow participants to hire legally responsible relatives to provide care (such as spouses or parents) and purchase nontraditional goods and services that increase independence or substitute for human assistance other than personal care. An eligible participant's service plan is based on an assessment of need for PAS and developed with a person-centered and directed planning process. In 2018, 21 states reported participating in the Section 1915(j) PAS state plan option.⁷⁸

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

Section 1915(k) of the SSA, the Community First Choice (CFC) Option, allows states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and receive an increased FMAP rate of 6 percentage points for doing so.⁷⁹ Eligible beneficiaries include those who are (1) eligible for medical assistance under the state plan, and (2) in an

⁷⁶ See Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule," *79 Federal Register* 2948-3039, January 16, 2014. For further information about regulatory implementation, see CMS, "Home and Community-Based Services Final Regulation," <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>.

⁷⁷ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.

⁷⁸ Kaiser Family Foundation, "State Health Facts, Medicaid Benefits: Self-Direct Personal Assistance Services, 2018," at <https://www.kff.org/other/state-indicator/medicaid-benefits-personal-assistance-services/>.

⁷⁹ CMS issued a final rule on the CFC Option; see Department of Health and Human Services, "Medicaid Program; Community First Choice; Proposed Rule," *77 Federal Register* 26362-26406, May 7, 2012. To the extent applicable, the increased FMAP under Section 9817 of ARPA (P.L. 117-2) was additive to the increased CFC FMAP specified in SSA Section 1915(k); see CMS, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency*, SMD# 21-003, May 13, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>.

eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet institutional level-of-care criteria to be eligible for CFC services.⁸⁰ States must provide these services on a statewide basis and in the most integrated community-based setting in which individuals with disabilities interact with nondisabled individuals.

Community-based attendant services and supports include attendant services and supports to assist eligible individuals in accomplishing ADLs, IADLs, and health-related tasks. Such services must be delivered under a person-centered plan of care in which attendants are selected, managed, and dismissed by the recipient (or his or her representative).⁸¹ Attendants must be qualified to deliver such services and may include family members (as defined by the HHS Secretary). This state plan benefit may also fund transition expenses when a beneficiary moves from a nursing facility to a community-based setting. Such expenses might include security deposits for an apartment or utilities, bedding, and basic kitchen supplies, among other expenses necessary to accomplish the transition. Additionally, states may provide services that increase independence or substitute for human assistance, such as nonmedical transportation or purchasing a microwave oven.⁸²

Additional requirements for states who offer the CFC optional benefit include (1) collaborating with a state-established Development and Implementation Council; (2) establishing and maintaining a comprehensive, continuous quality assurance system; and (3) collecting and reporting information for federal oversight and evaluation. In the first full fiscal year in which the state plan benefit is implemented, states must maintain or exceed the preceding fiscal year's Medicaid expenditures for individuals with disabilities or elderly individuals. In FY2020, nine states had a CFC option in place.⁸³

Medicaid HCBS Waiver Programs

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

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

In addition, states must demonstrate certain federal spending requirements over the period of the waiver program, referred to as cost neutrality and budget neutrality. States may also cap the

⁸⁰ Ibid., p. 26837.

⁸¹ 42 C.F.R. §441.550.

⁸² CMS, “Medicaid Program; Community First Choice; Final Rule,” 77 *Federal Register* 26828, May 7, 2012.

⁸³ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicare-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.

enrollment in these programs by setting a numerical limit. Because state Medicaid HCBS waiver programs often have greater demand than the number of available waiver “slots” for a given program, limiting the number of individuals receiving HCBS is one way for states to contain costs. As a result, many states maintain waiting lists (sometimes referred to as interest lists, planning lists, and registries) when their program slots are filled or when state legislatures do not fully fund the maximum number of waiver slots under the CMS-approved waiver program. Together, these waiver programs operate side-by-side with state plan authorities offering states a range of options in designing their LTSS benefit packages for eligible beneficiaries.

The most common waiver authority states use to provide HCBS to Medicaid beneficiaries is the Section 1915(c) waiver authority, named for the section of Medicaid law in which it is authorized. Individuals served under Section 1915(c) waiver programs live in a community-based setting but require the level of care offered in an institution, as defined by the state. Some states also use the waiver authority under SSA Section 1115, Research and Demonstration Projects, to cover HCBS. Of the 267 approved waivers for HCBS in FY2020, 255 were Section 1915(c) waivers and 12 were Section 1115 waivers.⁸⁴ States often have multiple Medicaid waiver programs that operate side-by-side with the Medicaid state plan authority. These waiver options are described in greater detail below.⁸⁵

Section 1915(c) Waivers

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

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

For a general description of the types of services covered under Section 1915(c) waivers, see **Table 2**. Note that states have the ability to name and define Section 1915(c) waiver services, as well as identify and define other services subject to HHS Secretary approval. Thus, there is

⁸⁴ Ibid., <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/>.

⁸⁵ SSA §1915(d) and (e) provide waiver authority for the provision of HCBS to elderly individuals and certain children, respectively. According to CMS, no state elects to provide services under these authorities and therefore they are not described in this report. Department of Health and Human Services, “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule,” *79 Federal Register* 2948-3039, January 16, 2014, p. 2956.

substantial state-to-state variation in naming conventions and service definitions across Section 1915(c) waiver programs.

Table 2. Covered Medicaid Services Under Section 1915(c) Home and Community-Based Services (HCBS) Waiver Programs

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

Source: SSA §1915(c) HCBS Waiver Application Instructions, “Appendix C: Participant Services,” at <http://157.199.113.99/WMS/help/35/appInstrSecC.html>.

Notes: Covered services are those listed in SSA §1915(c)(4)(B) [42 U.S.C. §1396n]. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

- a. Home health services are a mandatory state plan service. Home health aide services are a component of the state plan coverage. In a waiver, a state may elect to furnish home health aide services that are different in their scope and nature than the services offered under the state plan.
- b. Personal care services are an optional benefit that a state may furnish under its state plan, as provided in 42 C.F.R. §440.167. A state may offer personal care under a waiver when (1) it does not offer personal care under its state plan; (2) its coverage under the waiver differs in scope and nature from the coverage under the state plan; or (3) the state wishes to furnish personal care services in an amount, duration, or frequency that exceeds the limits in the state plan.

States must target a Section 1915(c) waiver to a specific population, such as individuals under age 65 with physical disabilities, individuals with intellectual or developmental disabilities, individuals aged 65 and older, or individuals with mental illness. States also have the option to combine target groups within one waiver program. As a result, states typically have more than one approved Section 1915(c) waiver, with each waiver program offering a specialized package of HCBS to a specific population.⁸⁶

Eligible waiver participants must meet certain financial requirements (including income and resource requirements) and state-defined needs-based eligibility criteria or level-of-care criteria that demonstrate the need for institutional LTSS. That is, individuals must have a level of need for LTSS that would otherwise be covered under a Medicaid institutional benefit, such as nursing facility care, ICF/IID, or hospital care.

Under Section 1915(c), the HHS Secretary has the authority to waive Medicaid’s “statewide” requirement to allow states to offer HCBS in a limited geographic area. The HHS Secretary may also waive the “comparability” requirement that services be comparable in amount, duration, or scope for individuals in particular eligibility categories. States may use the Section 1915(c) waiver to limit the number of individuals served by capping enrollment. The Section 1915(c) waiver is time limited, and waiver approvals are subject to reporting and evaluation requirements. State-approved Section 1915(c) waivers must also meet a “cost-neutrality” test, where average Medicaid expenditures for waiver participants cannot exceed institutional care expenditures that would have been incurred absent the waiver. Among states with Section 1915(c) waivers, the majority of states (75%) reported in 2018 that they used cost-containment strategies in addition to the federally mandated cost neutrality requirement, such as fixed expenditure caps either applied to individual participants or in aggregate as well as service limitations, and

Needs-Based Eligibility Criteria

In general, states determine an eligible individual’s need for Medicaid covered LTSS, both institutional and HCBS. To define needs-based eligibility, sometimes referred to as level-of-care criteria, states may use “functional” eligibility criteria such as an individual’s ability to perform certain *self-care activities*, often referred to as Activities of Daily Living (ADLs; e.g., eating, bathing, dressing, and walking). Functional eligibility criteria also include the ability to perform certain *household activities*, often referred to as Instrumental Activities of Daily Living (IADLs; e.g., shopping, housework, and meal preparation) that allow an individual to live independently in the community. Along with functional eligibility criteria, states may also use “clinical” criteria that include diagnosis of an illness, injury, disability or other medical condition, treatment and medications, and cognitive status, among other information (i.e., autism or intellectual disability, serious mental illness, traumatic brain injury).

Of the 267 HCBS waivers in FY2020, 242 waivers used the same functional eligibility criteria as required for nursing facility eligibility (i.e., institutional care). Moreover, 20 waivers across 10 states used functional eligibility criteria that were less restrictive than those required for institutional care, and 5 waivers across 4 states used functional eligibility criteria that were more restrictive. Self-care needs were more frequently required to establish functional eligibility than household activity needs. Among those HCBS waivers that require self-care needs for eligibility, most require individuals to need help with three or more activities.⁸⁷

⁸⁶ States have the option to combine target groups within one waiver program; see Department of Health and Human Services, “Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule,” *79 Federal Register* 2948-3039, January 16, 2014. Prior to this regulatory change, a Section 1915(c) waiver could only serve one of the following three target groups: (1) older adults, individuals with disabilities, or both; (2) individuals with intellectual disabilities, developmental disabilities, or both; or (3) individuals with mental illness.

⁸⁷ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices about Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at

geographic limits.⁸⁸ Expenditures under these waivers are matched at the state’s regular FMAP rate.

In FY2020, more than 1.9 million Medicaid beneficiaries were receiving services under Section 1915(c) HCBS waivers.⁸⁹ At that time, 46 states and DC offered at least one Section 1915(c) HCBS waiver, with states generally offering multiple waivers targeting HCBS to different groups.⁹⁰ Of the 255 Section 1915(c) HCBS waivers in FY2020, 46 states and DC had at least one Section 1915(c) waiver for populations with intellectual and/or developmental disabilities; 36 states and DC had at least one waiver targeting seniors and adults with physical disabilities; and 21 states targeted traumatic brain injury/spinal cord injury populations with their waivers. Additional populations served by Section 1915(c) waivers in FY2020 included medically fragile/technology dependent children (18 states), adults with physical disabilities (15 states), mental health (11 states), seniors (8 states), and HIV/AIDS (5 states).⁹¹

Section 1115 Research and Demonstration Projects

Section 1115 provides the HHS Secretary with broad authority to waive certain statutory requirements, thus allowing states to conduct research and demonstration projects under several programs authorized by the SSA, including Medicaid. Under Section 1115, the HHS Secretary may waive Medicaid requirements contained in Section 1902 of the SSA including, but not limited to, “freedom of choice” of provider, “comparability” of services, and “statewideness.” The HHS Secretary may also use Section 1115 waiver authority to provide federal funds for costs that are not otherwise matched under Section 1903 of the SSA.⁹² States must submit proposals outlining terms and conditions for proposed waivers to CMS and receive approval before implementing these programs.

Expenditures under approved Section 1115 waivers are financed through federal and state funds at the regular FMAP rate. However, unlike traditional Medicaid, costs associated with Section 1115 waiver programs must be “budget neutral” to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state’s existing Medicaid program. For example, costs associated with an expanded population (e.g., those not otherwise eligible under Medicaid) must be offset by spending reductions elsewhere within the Medicaid program. Several methods are used by states to generate cost savings for such waivers, such as (1) limiting benefit packages for certain

<https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/>.

⁸⁸ MaryBeth Musumeci, Molly O’Malley Watts, and Priya Chidambaram, *Key State Policy Choices About Medicaid Home and Community-Based Services*, Kaiser Family Foundation, *Issue Brief*, February 2020, p. 51, at <https://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services>.

⁸⁹ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, *Issue Brief*, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/>.

⁹⁰ Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices about Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, *Issue Brief*, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table1>.

⁹¹ *Ibid.*

⁹² SSA §1903 [42 U.S.C. 1396b] describes the conditions under which federal financial participation is available. SSA §1115(a)(2) stipulates that expenditures under a waiver are eligible for federal Medicaid funding under SSA §1903.

eligibility groups, (2) providing targeted services to certain individuals so as to divert them from full Medicaid coverage, and (3) using enrollment caps and beneficiary cost-sharing to reduce the amounts states must pay. Section 1115 waivers are time limited and approvals are subject to reporting and evaluation requirements.⁹³

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

In FY2020, four states (Arizona, New Jersey, Rhode Island, and Vermont) used Section 1115 waivers to provide Medicaid-covered HCBS to all eligible populations, and eight states (California, Delaware, Hawaii, New Mexico, New York, Tennessee, Texas, and Washington) used a combination of Section 1115 waivers and Section 1915(c) waivers to cover specific subsets of eligible individuals within a particular state.⁹⁴ Section 1115 waivers that provided HCBS covered over 1.1 million individuals during this time period.⁹⁵ Ten states (Arizona, California, Delaware, Hawaii, New Jersey, New Mexico, New York, Rhode Island, Tennessee, and Texas) used Section 1115 waivers to utilize Medicaid managed care programs for HCBS waiver recipients. Kansas and North Carolina used joint Section 1115 and Section 1915(c) HCBS waivers for capitated Medicaid managed care programs that included HCBS.⁹⁶

⁹³ SSA §1115 waiver projects are generally approved for a five-year period; however, states may seek up to a three-year extension for their existing waiver program. The approval process associated with each type of extension is defined in statute at SSA §1115(e) and at §1115(f), respectively.

⁹⁴ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices about Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/>.

⁹⁵ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table1>.

⁹⁶ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices about Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-issue-brief/>, see Figure 5.

Key Features of Selected Coverage of HCBS Under Medicaid

As previously discussed, states have a range of options in covering HCBS under Medicaid. **Table 3** compares key features of selected optional statutory authorities. These HCBS options are illustrative of the variation that exists within the Medicaid program for covering LTSS. Thus, while states may offer the same services, whether these services are offered as state plan or waiver service may determine whether all Medicaid beneficiaries have access to these services statewide or if access is limited to beneficiaries in a specific geographic area.

In addition, states that choose to offer HCBS under either the Section 1915(c) waiver or Section 1915(i) HCBS state plan authority have discretion in determining the HCBS benefit package, including the service type and definition. Thus, states may use different terms to refer to the same types of service, and similarly named services may be defined differently across waiver programs within a state as well as across states. For example, states may refer to personal care services as personal attendant services, personal assistance services, or attendant care services. This program-level variation makes it difficult to summarize and compare state Medicaid HCBS offerings both within a state and nationally.⁹⁷

⁹⁷ Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/>, see Table 1. For further discussion of HCBS taxonomy, see Victoria Peebles and Alex Bohl, *The HCBS Taxonomy: A New Language for Classifying Home and Community-Based Services, Medicare & Medicaid Research Review*, vol. 4, no. 3, CMS Office of Information Products & Data Analytics, 2014, <http://dx.doi.org/10.5600/mmrr.004.03.b01>.

Table 3. Key Features of Selected Coverage of Home and Community-Based Services (HCBS) Under Medicaid

Feature	Optional HCBS State Plan Benefits	§1915(c) HCBS Waiver	§1915(i) HCBS State Plan Benefits	§1915(k) Community First Choice State Plan Benefits	§1115 Waiver
Benefit Eligibility	States must provide services to all categorically eligible individuals who are enrolled in Medicaid and meet the needs-based eligibility criteria	States can target services to specific populations (e.g., age and diagnosis) who meet the needs-based eligibility criteria, and can limit the number of people served	States can target services to specific populations (e.g., age and diagnosis) but must provide services to all individuals in an eligibility group who meet the applicable financial and needs-based eligibility criteria ^a	States must provide services to all individuals who are enrolled in Medicaid in an eligibility group under the state plan that covers nursing facility services or, if not in such group, have an income that is at or below 150% of FPL. Individuals must also meet the needs-based eligibility criteria	States can target services to specific populations (e.g., age and diagnosis) who meet the needs-based criteria identified in the waiver, and can limit the number of people served
Geographic Criteria	Services must be available statewide	Services can be limited to certain geographic area(s)	Services must be available statewide	Services must be available statewide	Services can be limited to certain geographic area(s)
Needs-Based Eligibility Criteria	Beneficiaries must meet state-defined needs-based eligibility criteria	Beneficiaries must meet state-defined institutional level-of-care criteria	Beneficiaries must meet state-defined needs-based eligibility criteria that are less stringent than state-defined institutional level-of-care criteria Beneficiaries eligible for certain approved waiver programs with income that does not exceed 300% of the Supplemental Security Income (SSI) income federal benefit rate may also have to meet institutional level-of-care criteria	Beneficiaries must meet state-defined institutional level-of-care criteria	Beneficiaries must meet state-defined needs-based eligibility criteria
Coverable Services	Only federally specified services for each of the following: personal care, private duty nursing, case	A broad array of state-defined services, some of which are specified in federal statute, such as adult day health, case	Same as Section 1915(c) HCBS waiver	Coverage includes personal care attendant services and supports and may include transition costs (e.g., first	A broad array of state-defined services, some of which are specified in federal statute, such as adult day

Feature	Optional HCBS State Plan Benefits	§1915(c) HCBS Waiver	§1915(i) HCBS State Plan Benefits	§1915(k) Community First Choice State Plan Benefits	§1115 Waiver
	management, and rehabilitative services	management, habilitation, homemaker, home health aide, personal care, respite care, and other Secretary-approved services ^b		month's rent, utilities) and services that improve independence or substitute for human assistance, such as nonmedical transportation services	health, case management, habilitation, homemaker, home health aide, personal care, respite care, and other Secretary-approved services
Permits Payment of Relatives	Relatives who are not legally responsible may provide personal care	Relatives, including those legally responsible, may be paid to provide personal care and other services under specific circumstances as determined by the state	Same as Section 1915(c) HCBS waiver	Same as Section 1915(c) HCBS waiver	Same as Section 1915(c) HCBS waiver
FMAP Rate	Regular state FMAP rate	Regular state FMAP rate	Regular state FMAP rate	6% enhanced state FMAP rate ^c	Regular state FMAP rate
Subject to Renewal	No	Yes, initial term of three years, renewable for five-year periods ^d	Yes, renewable every five years	No	Yes, generally an initial term of five years, renewable for three to five year periods

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

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

- a. States may also create a new SSA §1915(i) eligibility pathway into Medicaid to increase access to HCBS for individuals who need a lower level of care than is provided in an institution. States may extend full Medicaid benefits to this new eligibility group.
- b. For individuals with chronic mental illness, the HHS Secretary may also approve the following services: day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).
- c. The SSA §1915(k) Community First Choice enhanced FMAP rate is the state's regular FMAP rate plus 6 percentage points.
- d. Per January 16, 2014, final rule (79 *Federal Register* 2948-3039), states may request an initial period of five years if the waiver includes individuals who are dually eligible for Medicare and Medicaid.

Appendix A. Optional Medicaid Long-Term Services and Supports (LTSS) State Plan Benefits

Table A-1. Coverage of Selected Optional Medicaid Long-Term Services and Supports (LTSS) State Plan Benefits, by State

State	Institutional Services				Home and Community-Based Services						
	ICFs/IID ^a	IMD 65 ^{+b}	Case Mngmt. ^c	CFC ^d	Health Homes ^e	PACE ^f	Pers. Care ^g	Priv. Duty Nurs. ^h	Rehab. ⁱ	State Plan HCBS ^j	Self-Directed PAS ^k
	2018	2018	2020	2020	2018	2020	2020	2020	2020	2020	2018
Alabama	Yes	Yes	Yes	—	Yes	Yes	—	No	No	—	No
Alaska	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	—	No
Arizona	Yes	Yes	Yes	—	No	No	—	Yes	—	—	No
Arkansas	Yes	Yes	No	—	—	Yes	Yes	No	No	Yes	—
California	Yes	Yes	No	Yes	Yes	Yes	Yes	No	—	Yes	Yes
Colorado	Yes	Yes	Yes	—	Yes	Yes	—	Yes	Yes	—	No
Connecticut	Yes	No	—	Yes	No	No	—	No	—	Yes	No
Delaware	No	Yes	Yes	—	No	Yes	Yes	Yes	Yes	Yes	No
Dist. of Columbia	Yes	Yes	—	—	Yes	No	Yes	—	—	Yes	No
Florida	Yes	Yes	Yes	—	No	Yes	Yes	Yes	Yes	—	Yes
Georgia	Yes	Yes	Yes	—	Yes	Yes	—	—	—	—	No
Hawaii	Yes	No	—	—	No	No	—	—	—	—	No
Idaho	Yes	Yes	Yes	—	No	No	Yes	Yes	Yes	Yes	Yes
Illinois	—	—	Yes	—	—	No	—	No	Yes	—	—
Indiana	Yes	Yes	Yes	—	No	Yes	Yes	No	Yes	Yes	Yes
Iowa	—	—	Yes	—	—	Yes	Yes	Yes	No	Yes	—

State	Institutional Services				Home and Community-Based Services						
	ICFs/IID ^a	IMD 65 ^{+b}	Case Mngmt. ^c	CFC ^d	Health Homes ^e	PACE ^f	Pers. Care ^g	Priv. Duty Nurs. ^h	Rehab. ⁱ	State Plan HCBS ^j	Self-Directed PAS ^k
	Year ^k	2018	2018	2020	2020	2018	2020	2020	2020	2020	2020
Kansas	Yes	Yes	Yes	—	Yes	Yes	Yes	No	Yes	—	Yes
Kentucky	Yes	Yes	No	—	Yes	No	—	Yes	No	—	No
Louisiana	Yes	Yes	Yes	—	No	Yes	Yes	No	Yes	—	No
Maine	Yes	Yes	Yes	—	Yes	No	Yes	Yes	Yes	—	No
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	—	Yes
Massachusetts	Yes	Yes	Yes	—	No	Yes	Yes	Yes	Yes	—	No
Michigan	No	Yes	Yes	—	Yes	Yes	Yes	Yes	No	Yes	Yes
Minnesota	Yes	Yes	Yes	—	Yes	No	Yes	—	—	—	Yes
Mississippi	Yes	Yes	No	—	Yes	No	—	Yes	No	Yes	No
Missouri	Yes	Yes	Yes	—	No	No	Yes	Yes	No	—	No
Montana	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	—	Yes
Nebraska	Yes	Yes	Yes	—	No	Yes	Yes	Yes	Yes	—	Yes
Nevada	Yes	No	No	—	—	No	Yes	Yes	Yes	Yes	No
New Hampshire	—	—	—	—	—	Yes	Yes	—	—	—	—
New Jersey	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes	—	Yes
New Mexico	Yes	Yes	No	—	Yes	Yes	Yes	—	—	—	No
New York	—	—	—	Yes	—	Yes	Yes	—	—	—	—
North Carolina	Yes	Yes	—	—	—	Yes	Yes	Yes	No	—	No
North Dakota	Yes	Yes	Yes	—	No	Yes	Yes	Yes	Yes	—	No
Ohio	Yes	No	No	—	Yes	Yes	—	Yes	No	Yes	Yes
Oklahoma	Yes	Yes	No	—	Yes	Yes	Yes	No	No	—	Yes

State	Institutional Services				Home and Community-Based Services						
	ICFs/IID ^a	IMD 65+ ^b	Case Mngmt. ^c	CFC ^d	Health Homes ^e	PACE ^f	Pers. Care ^g	Priv. Duty Nurs. ^h	Rehab. ⁱ	State Plan HCBS ^j	Self-Directed PAS ^k
	Year ^k	2018	2018	2020	2020	2018	2020	2020	2020	2020	2020
Oregon	Yes	Yes	No	Yes	No	Yes	Yes	No	No	—	Yes
Pennsylvania	Yes	Yes	Yes	—	No	Yes	Yes	Yes	Yes	—	No
Rhode Island	Yes	Yes	Yes	—	Yes	Yes	Yes	No	Yes	—	Yes
South Carolina	—	—	Yes	—	—	Yes	—	Yes	No	—	—
South Dakota	Yes	Yes	No	—	Yes	No	Yes	Yes	Yes	—	No
Tennessee	Yes	Yes	—	—	Yes	Yes	—	Yes	—	—	Yes
Texas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	—	Yes	Yes
Utah	Yes	Yes	No	—	No	No	Yes	Yes	Yes	—	Yes
Vermont	Yes	Yes	Yes	—	Yes	No	Yes	Yes	No	—	Yes
Virginia	Yes	Yes	Yes	—	No	Yes	—	Yes	No	—	Yes
Washington	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	—	No
West Virginia	Yes	Yes	Yes	—	—	No	Yes	Yes	Yes	—	Yes
Wisconsin	Yes	Yes	Yes	—	Yes	Yes	Yes	Yes	Yes	—	No
Wyoming	Yes	Yes	No	—	No	Yes	—	No	Yes	—	No
Total # of States and DC	44 Yes 2 No 5—	42 Yes 4 No 5—	30 Yes 14 No 7—	9 Yes 42—	23 Yes 19 No 9—	33 Yes 18 No 0—	37 Yes 0 No 14—	31 Yes 13 No 7—	24 Yes 15 No 12—	13 Yes 38—	21 Yes 24 No 6—

Source: CRS analysis of data for states and the District of Columbia (DC) from Kaiser Family Foundation: State Health Facts, and other published sources.

Notes: “Yes” = State reported covering this service; “No” = State reported not covering this service; “—” = State either did “not respond” or field was blank and no data were reported.

Medicaid LTSS benefit coverage varies across states in the amount, duration, and scope of the benefit, as well as the package of included services within a specific benefit (e.g., SSA §1915(i) State Plan HCBS and (j) Self-Directed PAS). Some of the state plan services in this table may vary by category of Medicaid enrollee (e.g., alternative benefit plan or managed care enrollee) or active waivers. Data range consists of a calendar year (CY) or a federal fiscal year (FY), depending on the source.

- a. ICFs/IID refers to Intermediate Care Facilities for Individuals with Intellectual Disabilities. Federal Medicaid law uses the term “intermediate care facilities for the mentally retarded” and the abbreviation “ICFs/MR”; however, federal agencies use the term “intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).” Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Intermediate Care Facility Services for Individuals with Intellectual Disabilities, 2018,” at <http://kff.org/medicaid/state-indicator/intermediate-care-facility-services-for-the-mentally-retarded/>.
- b. IMD 65+ refers to Institutions for Mental Diseases for individuals aged 65 and older. Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Inpatient Hospital, Nursing Facility, and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and older, 2018,” at <https://www.kff.org/medicaid/state-indicator/services-in-institutions-for-mental-disease-age-65-and-older/>.
- c. Case management refers to the optional state plan benefit for case management. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table8>.
- d. CFC §1915(k) refers to the Community First Choice state plan option under SSA §1915(k). Centers for Medicare & Medicaid Services (CMS), “Medicaid State Plan Amendments.” Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.
- e. Health Homes refers to health homes as established by Section 2703 of the Affordable Care Act. Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: ACA Health Homes, 2018,” at <https://www.kff.org/other/state-indicator/medicaid-benefits-aca-health-home/>.
- f. PACE refers to Program for All-inclusive Care of the Elderly. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table10>.
- g. Pers. Care refers to personal care services. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.
- h. Priv. Duty Nurs. refers to Private Duty Nursing. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table7>.
- i. Rehab. refers to rehabilitative services. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-appendix/#table9>.
- j. State Plan HCBS §1915(i) refers to the Home and Community-Based Services state plan option under the SSA §1915(i) of the SSA. Molly O’Malley Watts, MaryBeth Musumeci, and Meghana Ammula, *State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic*, Kaiser Family Foundation, Issue Brief, March 2022, at <https://www.kff.org/report-section/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic-appendix/#table6>.
- k. Self-Directed PAS §1915(j) refers to the Personal Assistance Services state plan option under SSA §1915(j). Kaiser Family Foundation, “State Health Facts, Medicaid Benefits: Self-Direct Personal Assistance Services, 2018,” at <https://www.kff.org/other/state-indicator/medicaid-benefits-personal-assistance-services/>.
- l. Data for 2018 are as of July 1, 2018; data for 2020 are for FY2020.

Appendix B. Medicaid Long-Term Services and Supports (LTSS) Expenditures

Data from the latest Medicaid LTSS annual expenditures report, sponsored by CMS, provides detailed information about combined federal and state Medicaid LTSS expenditures for FY2019 by type (institutional versus HCBS) and service category.⁹⁸ Expenditure data are from several sources, including Medicaid CMS-64 expenditure reports for state plan and waiver services, state-reported managed LTSS (MLTSS) expenditures, Money Follows the Person (MFP) Rebalancing Demonstration Program worksheets for proposed budgets, and CMS 372 report data for SSA Section 1915(c) HCBS waiver programs. Note that one limitation of the FY2019 Medicaid LTSS expenditure data is the exclusion of four states due to missing data. These states (California, Delaware, Illinois, and Virginia) were unable to submit MLTSS expenditure data for the FY2019 period and MLTSS spending accounts for a large share of overall Medicaid LTSS spending in each of those states.

Figure B-1 shows the distribution of FY2019 Medicaid HCBS expenditures (both federal and state) by service category. SSA Section 1915(c) HCBS waiver programs accounted for more than half of HCBS expenditures in FY2019 (50.7%),⁹⁹ followed by the personal care state plan option (21.7%) and other HCBS provided under MLTSS financing and delivery models (8.6%). These “HCBS MLTSS: Other” services include adult day care services, home-delivered meals, durable medical equipment, and respite services, among others. Another 7.4% of spending was for the SSA Section 1915(k) CFC state plan option and 5.0% was for home health. Other HCBS was 3.7% of spending and includes the following service categories: case management, Program for All-Inclusive Care of the Elderly (PACE), private duty nursing, Health Homes, SSA Section 1915(i) HCBS state plan option, and SSA Section 1915(j) self-directed personal assistance services, as well as expenditures for the Money Follows the Person Rebalancing Demonstration Program.¹⁰⁰ Finally, 2.9% of Medicaid HCBS spending was for rehabilitative services.

Figure B-1 also shows the distribution of Medicaid institutional expenditures (both federal and state) for FY2019. The majority of institutional LTSS expenditures were spent on nursing facility services (80.0%), followed by Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) (11.8%), mental health facilities (7.9%),¹⁰¹ and “other” institutional LTSS expenditures that are reported by states in their MLTSS data (0.4%).¹⁰²

⁹⁸ Caitlin Murray et al., *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 019*, Mathematica Policy Research, December 9, 2021, at <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss expenditures2019.pdf>.

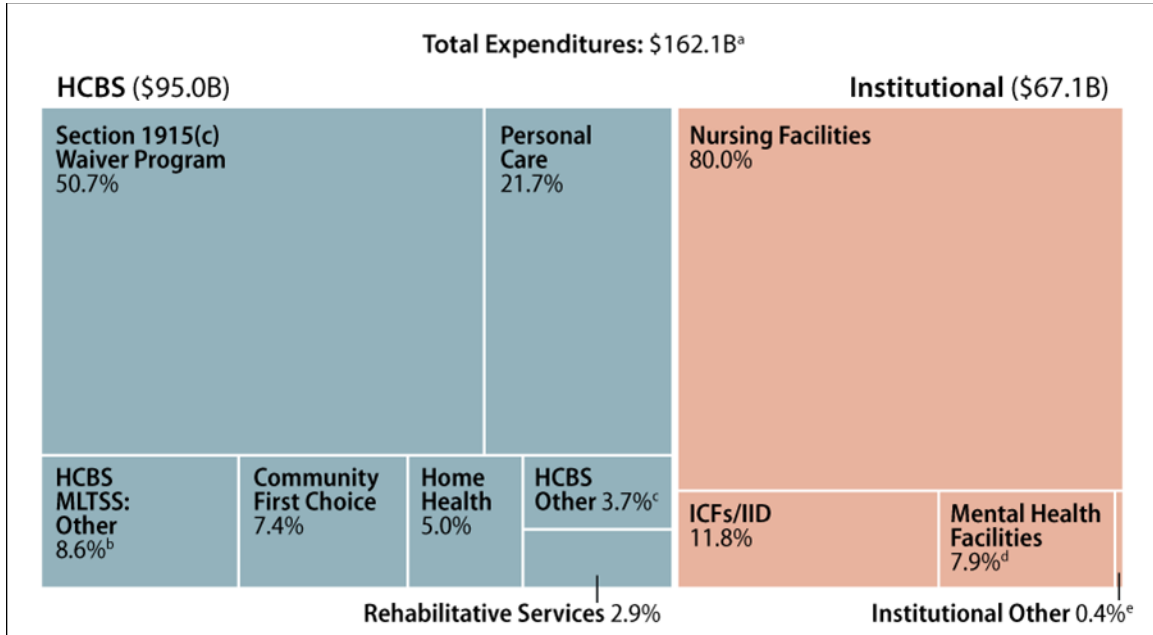
⁹⁹ New Jersey and Rhode Island did not have any SSA Section 1915(c) waiver programs in FY2019; however, these states reported fee-for-service HCBS expenditures that were provided through SSA Section 1115 waiver programs, which were captured as SSA Section 1915(c) HCBS waiver program expenditures in this analysis.

¹⁰⁰ Other HCBS also includes state-reported SSA Section 1115 demonstration expenditures for Vermont that do not fit into one of the existing service categories; these included expenditures for adult day care services, community and rehabilitative treatment (CRT), enhanced residential care (ERC), and other HCBS and residential services.

¹⁰¹ Mental health facility expenditures include inpatient psychiatric hospital services for individuals under age 21 and Institution for Mental Diseases (IMD) services for individuals aged 65 or older, as well as mental health disproportionate share hospital (DSH) payments.

¹⁰² Other institutional LTSS expenditures also include state-reported MLTSS from Arizona, Hawaii, Minnesota, and South Carolina, and SSA Section 1115 waiver expenditures from Vermont that do not fit into one of the existing service categories, such as expenditures for inpatient or residential substance use disorder treatment.

Figure B-I. Total Medicaid Long-Term Services and Supports (LTSS) Expenditures, by Type and Service Category, FY2019



Source: Adapted from Caitlin Murray et al., *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019*, Mathematica Policy Research, December 9, 2021, at <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf>.

Notes: HCBS = home and community-based service; MLTSS = Medicaid managed Long-Term Services and Supports; ICFs/IID = Intermediate Care Facilities for Individuals with Intellectual Disabilities.

- a. Medicaid LTSS expenditures for California, Delaware, Illinois, and Virginia were excluded because of missing data.
- b. “HCBS MLTSS: Other” includes expenditures for adult day care services, home-delivered meals, durable medical equipment, and respite services, among others.
- c. “HCBS Other” includes expenditures for the following service categories: case management, Health Homes, Money Follows the Person Rebalancing Demonstration Program, Program for All-Inclusive Care of the Elderly (PACE), private duty nursing, SSA Section 1915(i) Optional HCBS State Plan, and SSA Section 1915(j).
- d. “Mental Health Facilities” include expenditures for inpatient psychiatric hospital services for individuals under age 21, Institution for Mental Diseases (IMD) services for individuals aged 65 or older, and mental health disproportionate share hospital (DSH) payments.
- e. “Institutional Other” includes expenditures for other institutional LTSS and MLTSS reported by states in their data that do not fit into one of the existing service categories (such as SSA Section 1115 waiver service expenditures and expenditures for inpatient or residential substance use disorder treatment).

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