Legal Basics: Medicaid Long-Term Services and Supports

NATIONAL CENTER ON LAW & ELDER RIGHTS

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Eric Carlson and Gelila Selassie, Justice in Aging

Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Key Lessons

1. **Medicaid provides basic health care coverage.** A state's Medicaid program must cover physician services, hospital services, nursing facility services, and other specified services. A state has the option to cover home and community-based services (HCBS).

2. **Medicaid covers nursing facility care on an ongoing basis for Medicaid beneficiaries who need it.** Medicaid programs offer coverage for nursing facility services with no set coverage limit. Because the Medicaid program is the last-resort, safety-net payor, the clinical standard for coverage is based simply on whether the person needs nursing facility care. Implementation of this standard varies from state to state.

3. **Acceptance of Medicaid or Medicare reimbursement obligates nursing facilities to comply with the federal Nursing Home Reform Law.** Under the federal standards, care must be provided under a care plan developed through a process directed by the resident. Care must be provided in a manner sufficient so that the resident can attain or maintain the highest practicable level of functioning. The standards apply to all residents, regardless of reimbursement source, and the facility cannot discriminate based on form of payment in providing services.

4. **States can provide HCBS through a variety of options, including waivers and state plan amendments, and services may be reimbursed through Fee-For-Service (FFS) Medicaid or managed care.** An HCBS waiver allows a state to provide home and community-based services as an alternative to nursing facility care. The state can limit these services to a particular region of the state, or set an enrollment limit, if such limits are approved by the federal government. The state remains subject to the requirement of the Americans with Disabilities Act that state programs not result in unnecessary institutionalization.

    - **HCBS state plan amendments authorize home and community-based services without enrollment limits.** Services cannot be limited by geographic region or through an enrollment cap, although eligibility can be targeted at particular populations. Clinical eligibility standards must be needs-based, and thus cannot be tied to a particular diagnosis.

    - **The Community First Choice program provides additional incentives for a state to offer HCBS.** The federal government must contribute an additional six percent of the cost of HCBS provided through the Community First Choice program. Services are not subject to enrollment limits.

5. **Under Fee-For-Service delivery systems, states directly pay HCBS providers for each service they provide when services are rendered.** However, an increasing number of states are under a managed care delivery system where the state contracts with Managed Care Organizations (MCOs) and provides a set payment per Medicaid enrollee.

6. **The HCBS Settings Rule requires HCBS to be provided in settings that facilitate integration with the greater community, and choice by the service recipient.** Certain standards apply specifically to residential settings such as assisted living facilities, including due process protections in evictions.

1. Medicaid Provides Basic Health Care Coverage

The Medicaid program is a collaboration between the federal government and individual states. Federal law and policy set the basic rules, but each state has significant flexibility to customize its program by adjusting benefit packages and eligibility standards, seeking rule waivers, and taking various other actions. The Medicaid program provides for coverage of basic health care for persons who otherwise would be unable to afford such coverage. A state is required to offer physician services, hospital services, nursing facility services, and other mandatory services. A state has the option of offering other services such as dental services, in-home personal care services, physical therapy, and case management services.

Home and community-based services (HCBS), although optional, are particularly important to older adults and to persons with disabilities. HCBS are a package of services that are provided as an alternative to care provided in a nursing facility, intermediate care facility, or other institution. The exact package of services varies from state to state.

2. Medicaid Covers Nursing Facility Care on an Ongoing Basis for Medicaid Beneficiaries Who Need It

As mentioned above, nursing facility services are a mandatory service—state Medicaid programs must offer them to Medicaid beneficiaries who need those services. The method for determining clinical need varies from state to state. Some states use algorithms tied to assessment protocols; other states' determinations are more subjective.

Notably, and unlike Medicare coverage of nursing facility care, Medicaid coverage for nursing facility care is not time-limited. This open-endedness is appropriate, given Medicaid's status as the safety-net payor of last resort.

3. Acceptance of Medicaid or Medicare Reimbursement Obligates Nursing Facilities to Comply with the Federal Nursing Home Reform Law

Acceptance of federal reimbursement obligates a nursing facility to follow federal quality of care standards in reference to all facility residents, regardless of the resident's reimbursement source. Upon admission, a resident is assessed through an instrument known as the MDS (Minimum Data Set). In turn, information from the assessment is used as part of preparing a care plan. The care plan process is done through a team process controlled by the resident to the extent possible. The team must include the resident's physician, facility staff and other persons chosen by the resident.[1]

The facility must provide health care services so that the resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being.[2] Therapy should be provided based on the resident's need for such services, based on a physician order, and cannot be limited only to those residents receiving specific Medicare Part A reimbursement based on receipt of therapy services.[3] More generally, the facility cannot discriminate based on reimbursement source in providing services.[4]

1 42 C.F.R. § 483.21.
2 42 C.F.R. § 1396r(b)(2).
3 42 C.F.R. § 483.65.
4 42 C.F.R. § 483.10(a)(2).

Regarding quality of life, the facility must make reasonable accommodations for a resident's personal preferences.[5] Requests for such accommodations should be raised by residents during the care planning process.

A resident has the right to accept a visitor at any time of the day or night. For visitors who are not family members, the facility has some authority to assess "reasonable clinical and safety restrictions."[6]

A resident can be transferred or discharged against his or her will only under one of the following six conditions:

1. The resident no longer needs nursing facility care;
2. The resident needs care beyond the care that can be provided in a nursing facility;
3. The resident's presence in the facility endangers others' health;
4. The resident's presence in the facility endangers others' safety;
5. The resident has failed to pay the facility for services; or
6. The facility is going out of business.

The facility must give written notice, generally at least 30 days prior to the proposed transfer or discharge. The resident has the right to challenge the proposed transfer/discharge in an administration hearing.[7]

4. Medicaid Covers Home and Community-Based Services (HCBS) Through a Variety of Mechanisms

HCBS waivers allow states to provide home and community-based services as an alternative to nursing facility care.

Federal law authorizes the federal government to offer a package of home and community-based services as an alternative to institutional care—for older adults, usually nursing facility care. Eligibility for the program is limited to those persons whose health care needs qualify him or her for coverage of nursing facility expenses. The program must be cost-neutral overall: as a result of the waiver, the Medicaid program's overall expenses must be no greater than they would have been if the waiver had never been granted. Each individual state can decide whether overall cost neutrality is adequate, or whether the state instead wants to require that the Medicaid expense for each HCBS recipient is no greater than it would have been if that recipient had received nursing facility services rather than HCBS.[8]

These HCBS waivers are frequently called Section 1915(c) waivers, since the waiver authority is contained in Section 1915(c) of the Social Security Act.[9] A state applies through submission of a standardized waiver application that directs a state to make various choices which determine program attributes such as eligibility standards, services provided, and program safeguards.[10]

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5 42 C.F.R. § 1396r(c)(1)(A)(v)(I).
6 42 C.F.R. § 483.10(f)(4).
7 42 C.F.R. § 483.15(c).
8 42 U.S.C. § 1396n(c)(2)(D).
9 Section 1915 is codified as section 1396n of Title 42 of the United States Code.
10 Application for a § 1915(c) HCBS Waiver (Version 3.5).

Services vary from state to state, depending on the state's choices. The possible services include (but are not limited to) personal care, case management, homemaker services, home health aide services, adult day health care, assisted living, and respite care.[11] At a state's option, services can be self-directed. This may include control over the training, hiring and firing of care providers (employer authority), discretion over how to allocate an HCBS budget (budget authority), or both. A logistical safeguard in budget authority can be provided by financial management services that may be provided by a governmental entity or a private entity, based on the terms of the waiver document.[12] HCBS under a waiver are not an entitlement, and a state may request permission from CMS to limit enrollment to a set number of persons, to particular populations, and/or to specific regions of a state.[13] Even though waitlists are authorized by Medicaid law, they may run afoul of the Americans with Disabilities Act, if a state's policies lead to unnecessary institutionalization of persons who would prefer to live in the community, and could do so if given adequate support.[14]

HCBS State Plan Amendments Authorize Home and Community-Based Services Without Enrollment Limits

Pursuant to 2005's Deficit Reduction Act, federal law authorizes states to provide HCBS through amending the state's Medicaid plan, rather than obtaining authority through a waiver. Again, services can only be covered for persons whose health care needs would qualify him or her for care in a nursing facility (or another specified institution).[15] One significant difference is the fact that state plan services cannot be limited to a particular number of persons, or a particular region of a state. Eligibility can, however, be restricted to particular Medicaid populations.[16]

Financial eligibility for state-plan HCBS depends upon:

1. The person's income not exceeding 150% of the federal poverty level; or
2. The person meeting financial eligibility standards for HCBS provided in the state through an HCBS waiver or a Medicaid demonstration waiver, as long as the person's income does not exceed 300% of the federal Supplemental Security Income (SSI) level.[17]

The second route to financial eligibility was added after the program's original enactment, to ensure that, in effect, the financial eligibility standards for HCBS provided through a state-plan amendment do not exclude persons who could be financially eligibile through other HCBS mechanisms in the state.

Clinical eligibility standards must be "needs-based,"[18] and a diagnosis is not enough to determine eligibility based on need. A criterion "can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need."[19] The statutory language specifically references an inability to perform two activities of daily living, but use of that particular standard is not mandatory.[20]

For consistency within a state, eligibility for nursing facility services must also be determined through needs-based standards. To encourage use of HCBS, those standards for institutional care must be more stringent than the standards used by the state to determine eligibility for the state-plan HCBS.[21]

11 Application for a § 1915(c) HCBS Waiver (Version 3.5), Appendix C-1.
12 5 Application for a § 1915(c) HCBS Waiver (Version 3.5), Appendix E.
13 42 U.S.C. § 1396n(c)(3).
14 See, e.g., Olmstead v. L.C., 527 U.S. 581 (1999).
15 42 U.S.C. § 1396n(i)(1).
16 42 U.S.C. § 1396n(i)(7).
17 42 U.S.C. § 1396n(i)(1), (6)(A).
18 42 U.S.C. § 1396n(i)(1)(A).
19 42 C.F.R. § 441.715(a).
20 42 U.S.C. § 1396n(i)(1)(D)(i).
21 42 U.S.C. § 1396n(i)(1)(B).

All HCBS must be provided under a written care plan based on an assessment. At a state's option, the HCBS may include self-directed services. Such services are "planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services."[22]

The Community First Choice Program Provides Additional Incentives for a State to Offer HCBS

The Community First Choice program offers states an incentive that lessens the state's financial risk in offering HCBS to more persons. In return for the state offering HCBS throughout the state, without an enrollment limit, the federal financial participation share increases by six percent.[23] If, for example, the federal government ordinarily covers 60 percent of the state's Medicaid expenses, the federal government would cover 66 percent of the expenses attributable to Community First Choice HCBS.

The Community First Choice program utilizes eligibility standards that are identical or similar to the standards used in other HCBS programs. Clinical eligibility depends upon the person's needs being significant enough to qualify him or her for nursing facility care (or, in some cases, care in another specified institution).[24] Financial eligibility standards are similar to those under the HCBS state-plan authority: income of no more than 150% of the federal poverty level, or a financial status that would qualify the person for coverage of nursing facility care.[25] In many states, this "eligibility for nursing facility care" standard translates to having income of no more than 300% percent of the federal SSI level.

The services provided are similar to those offered under HCBS waivers and other HCBS programs. In addition, the statutory authorization requires inclusion of:

1. Services that assist the person in acquiring or maintaining the ability to perform activities of daily living;
2. Back-up systems to ensure continuity of services and supports; and
3. Training on how to hire, manage and dismiss personal care workers.[26]

Also, a program may include payment for transition costs such as bedding, basic kitchen supplies, rent and utility deposits, and payment for the first month of rent. A program also may include payment for equipment or other items that may increase independence or substitute for human assistance.[27]

5. A Large Number of States are Using Managed Care Delivery Systems to Pay for HCBS

Traditionally, providers were reimbursed for Medicaid services under a Fee-For-Service (FFS) model where Medicaid pays the provider for each service they provide the Medicaid enrollee. Now, states increasingly are using managed care delivery systems for their Medicaid programs. Instead of reimbursing for each service provided, the state contracts with a Managed Care Organization (MCO) and pays the MCO a set amount per Medicaid enrollee regardless of the services the enrollee receives.

22 42 U.S.C. § 1396n(i)(1)(G)(iii)(II).
23 42 U.S.C. § 1396(k)(2).
24 42 U.S.C. § 1396n(k)(1).
25 Id.
26 42 U.S.C. § 1396n(k)(1)(B).
27 42 U.S.C. § 1396n(k)(1)(D).

While older adults and people with physical disabilities are less likely to be enrolled in managed care compared to other Medicaid populations, a growing number of states are using managed care for complex needs like LTSS.[28]

Aside from the payment process, there are other key differences between FFS and managed care systems. Under FFS, the enrollee is typically responsible for finding their Medicaid providers or confirming if a provider takes Medicaid. Under managed care, the MCOs connect the enrollees to providers that are in-network with the MCO. As mentioned, MCOs receive capitated payments for enrollees, meaning they receive a set payment regardless of how many services the individual may need. As a result, MCOs may have higher denial rates for preauthorized services than other types of administrators.[29]

In 2024, CMS published regulations to improve standards and increase transparency among managed care plans. The regulations, in part, require states to maintain a single, publicly-accessible website containing information about various managed care plans.[30] The regulations also added additional guidance for managed care plans that cover "in lieu of services" (ILOS) — a set of services provided by MCOs to substitute for traditional state plan services. The regulation expanded the definition of ILOS to include more services aimed at addressing unmet social needs, and provides additional oversight on ILOS spending.[31]

6. New Standards Require HCBS to be Provided in Settings that Facilitate Integration with the Greater Community

As discussed above, HCBS are meant to provide an alternative to care in a nursing facility or other institution. To ensure that HCBS are appropriately non-institutional, the Settings Rule sets standards for integration with the community, and for other characteristics of non-institutional care. Individual states spent several years developing procedures to bring their services and providers into compliance. States had until March 17, 2023 to be in compliance with the rule, although CMS has granted some extensions for limited purposes.[32]

Under the standards, the HCBS setting must support "full access of individuals receiving Medicaid HCBS to the greater community;" this includes autonomy in receiving services, controlling personal resources, and seeking employment.[33] The setting and provider must honor a recipient's rights to privacy and dignity, and also must optimize the recipient's ability to make choices. These choices include such matters as daily activities and with whom to interact. Especially relevant to HCBS, the right to choose is extended to services and supports, and who provides them.[34]

Additional standards apply to a provider-owned or controlled setting—an assisted living facility or other residential facility, for example. The living unit must be a specific physical place that can be rented or owned under a legally enforceable agreement. Under the rule, HCBS enrollees must have the "same responsibilities and protections" as provided under the jurisdiction's landlord-tenant law or, if the setting is not subject to landlord-tenant law, then a written agreement must provide "comparable" protections to those provided under landlord-tenant law. Some states provide for an administrative hearing system, even though the law does not specifically reference such a system as an option.

28 Elizabeth Hinton and Jada Raphael, KFF, "10 Things to Know About Medicaid Managed Care" (2024).
29 Id.
30 42 C.F.R. § 438.10(c).
31 42 C.F.R. §§ 438.2, 438.3(e), 438.16.
32 42 C.F.R. § 441.301(c)(6).
33 42 C.F.R. § 441.301(c)(4)(i).
34 42 C.F.R. § 441.301(c)(4)(iii)-(v).

Privacy in residential units must be supported by lockable doors. A recipient also must have freedom to decorate and furnish his or her living unit, and to choose a roommate.[35] Recipients must have the freedom and support to control their own schedules and activities, and must have access to food at any time.[36] A recipient can accept a visitor at any time of the day or night.[37]

The requirements for the provider-owned or controlled settings can be modified in the recipient's person-centered service plan, if the modification is supported by a specific assessed need. The service plan must identify the need, document previous interventions, describe the modification that is directly proportionate to the specified assessed need, and provide for periodic review to ensure that the modification continues to be necessary. A modification can be done only with the recipient's informed consent.[38]

Conclusion

Long-term services and supports are particularly important for older Medicaid recipients, since they often require assistance with activities of daily living, along with other services and supports. Services in a nursing facility are mandatory, and HCBS are optional, but all states offer some type of HCBS. Year by year, most Medicaid programs overall are expanding efforts to provide HCBS as a more viable alternative to nursing facility services or other institutional services.

Additional Resources

- Medicaid Statute: 42 U.S.C. §§ 1396- 1396w-5
- Medicaid Regulations: 42 C.F.R. §§ 430.1- 435.1015
- Centers for Medicare & Medicaid Services Website
- NCLER: Medicaid 101
- NCLER: Basics of Nursing Home Evictions
- NCLER: Long-Term Services and Supports
- Justice in Aging Resources

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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35 42 C.F.R. § 441.301(c)(4)(vi)(B).
36 42 C.F.R. § 441.301(c)(4)(vi)(C).
37 42 C.F.R. § 441.301(c)(4)(vi)(D).
38 42 C.F.R. § 441.301(c)(4)(vi)(F).