STETSON LAW

Long-Term Supports and Services Boot Camp

November 8, 2024

STETSON LAW

Center for Elder Justice

Access and Justice For All®

STETSON LAW

Long-Term Supports and Services Boot Camp

To purchase additional copies, contact:

Center for Elder Justice
1401 61st Street South
Gulfport, FL 33707
Phone: (727) 562-7393
Email: elderlaw@law.stetson.edu

STETSON LAW

Center for Elder Justice

Access and Justice For All®

STETSON LAW

Sponsors
&
Exhibitors

Stetson University College of Law expresses its appreciation to our sponsors and exhibitors for their support of the 2024 National Conference on Special Needs Planning and Special Needs Trusts

STETSON LAW

Center for Elder Justice

Access and Justice For All®

STREAMLINE THE WAY YOU MANAGE CAREGIVER PAYROLL FOR YOUR CLIENTS.

Eliminate administrative complexity and protect your clients' assets with an all-in-one HR and payroll solution that is custom-built for special needs trusts.

PAYROLL & EMPLOYEE ADMINISTRATION

Payroll processing, W-2s, tax reporting, background checks, timecards, recordkeeping, and benefits

HUMAN RESOURCES & COMPLIANCE

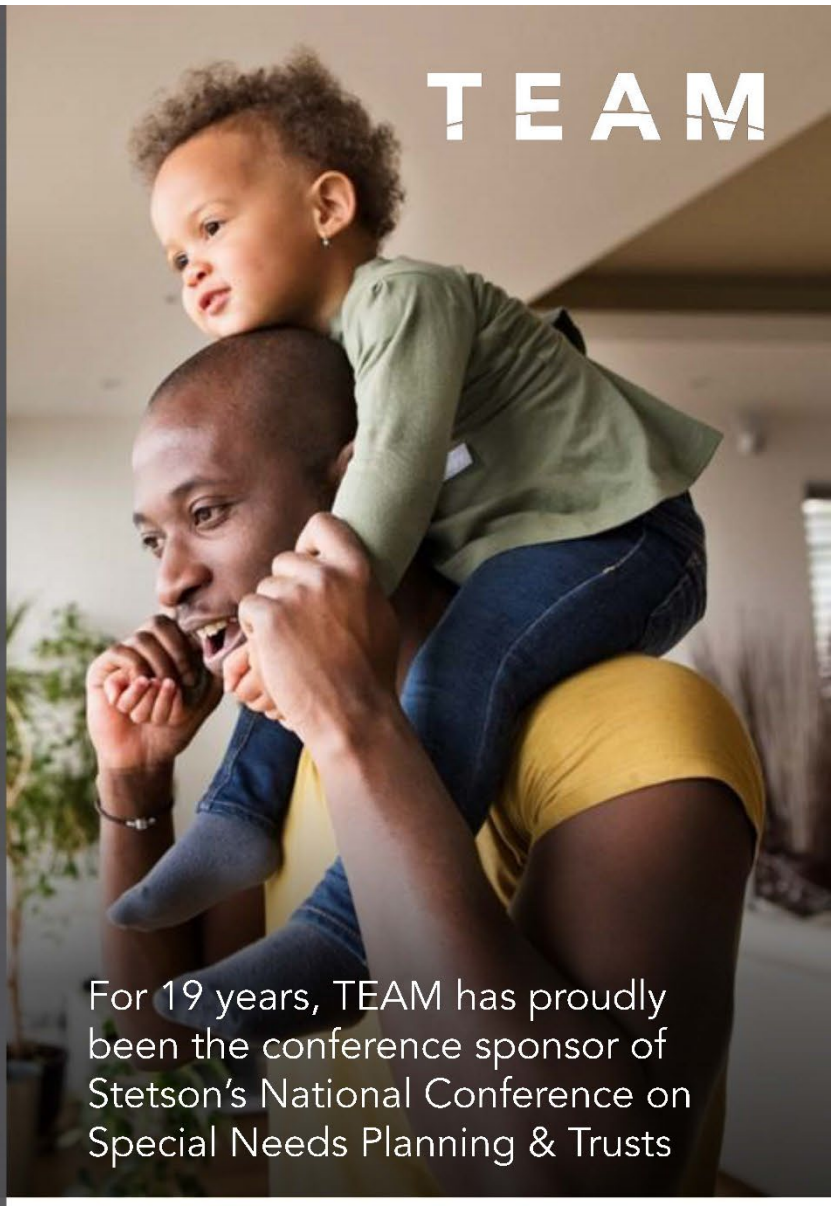
Compliance with all applicable employment laws; ongoing HR guidance; custom policies, handbooks, and job duties

EMPLOYMENT LIABILITY PROTECTION

Workplace insurance policies, full liability protection and indemnification, and expert risk mitigation strategies

WHITE-GLOVE SUPPORT

Dedicated Payroll, HR, and Client Service Specialists that are directly available via phone and email



9.7
out of 10 average satisfaction rating

21
years in business serving as Employer of Record

400+
of the nation's largest banks and trust companies are clients

4,000+
clients and families served across all 50 states

GET IN TOUCH 877-767-8728 contact@teamemployer.com teamemployer.com

Protecting Your Assets
Preserving Your Legacy

ABOUT LEGACY

Legacy Enhancement offers a different option for those who do not wish to establish a trust with a traditional bank or large trust company. We offer the same professional trust management as larger entities with a level of personalized care and low fees that big banks and other trust companies lack.

WHY CHOOSE US?

- Affordable Fees
- Advanced Trust Technology
- Professional Management
- Focus on Client Care

TRUST SERVICES

- Pooled Trust
- Minor Trusts
- Discretionary Trusts
- First-Party Special Needs Trusts
- Third-Party Special Needs Trusts

LEGACY ENHANCEMENT TRUST

Contact Us Today
866-587-8306
legacyenhancement.org

SOUTHEASTERN TRUST COMPANY

Experts in Administering Special Needs Trusts

"We know our clients are in great hands when we make a referral to Southeastern Trust. They are the perfect fit for our clients who are intimidated by traditional trust companies."

- ESTATE PLANNING ATTORNEY

www.setrustco.com/snt

PROTECTING ASSETS. PRESERVING ELIGIBILITY. ENRICHING LIVES.

Life Enrichment Trust, Inc. (LET) enables individuals with disabilities receiving Social Security, Supplemental Security Income, and/or Medical Assistance to secure their financial futures without endangering their source of monthly income, medical insurance, or other governmental benefits.

LIFE® ENRICHMENT TRUST INC.

Inspire Trust Company, N.A.

is proud to sponsor the

Stetson 2024 National Conference on Special Needs Planning and Special Needs Trusts

Creating exceptional client experiences for the families that you work with is our motivation.

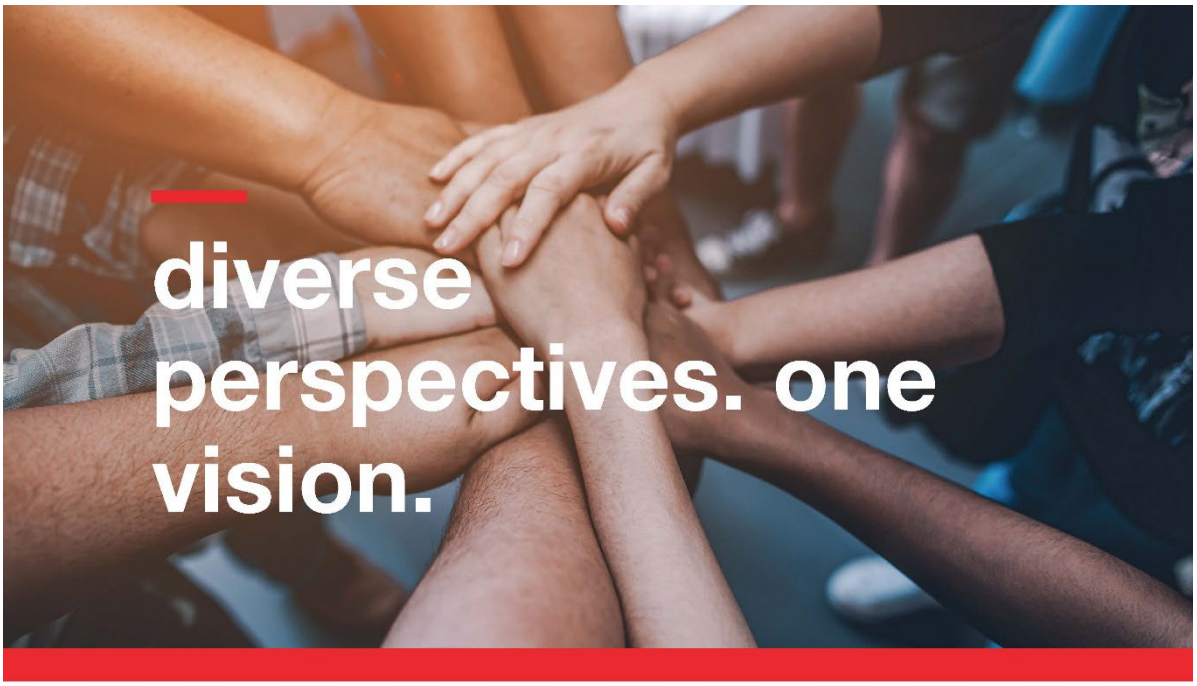
We are a national bank focused on clients with life-changing events and are here to support you and the families each step of the way.

Visit our website at:
www.inspiretrustco.com

Contact us at:
877-734-0963 or
info@inspiretrustco.com

Inspire Trust

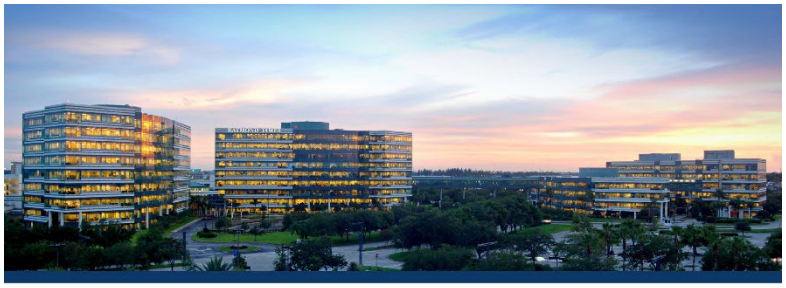
Conference Representative:
Melissa L. Barnhardt
Interim Chief Fiduciary Officer
754-755-5092
mbarnhardt@inspiretrustco.com



At KeyBank, diversity, equity, and inclusion are part of our corporate fabric. In everything we do, we support a culture that embraces and celebrates our differences, where every person feels included, empowered, and valued. This commitment is reflected throughout our business, from the teammates we hire and the clients we serve to the suppliers we use and the communities that welcome us.

KeyBank is honored to support Stetson Laws 2024 National Conference on Special Needs Planning and Special Needs Trusts.

KeyBank
Opens Doors.®



Here, **trust** runs deeper.

Raymond James Trust isn't your traditional trust company – despite a long and successful history of serving the needs of clients across the country. We're not owned by a bank. Instead, our team is part of one of the largest independent financial services firms in the country – free to offer an uncommon degree of flexibility, create tailored solutions to meet unique needs, and build deep personal relationships with you and your clients.

- **150-plus seasoned trust professionals** knowledgeable in estate, tax and trust law
- A focus on tailored solutions, with a **dedicated trust officer on every account**
- Comprehensive **trust administration and estate settlement** services
- **Specialty services,** including special needs trust administration, real estate, specialty assets, beneficiary and trusteed IRAs, philanthropic strategies and more

OUR LOCATIONS:

St. Petersburg, FL | Boca Raton, FL | Columbus, GA
New York, NY | Memphis, TN | Houston, TX

RAYMOND JAMES *Trust*

INTERNATIONAL HEADQUARTERS: THE RAYMOND JAMES FINANCIAL CENTER
880 CARILLON PARKWAY // ST. PETERSBURG, FL 33716 // 727.567.2300 // RAYMONDJAMESTRUST.COM

SNA SPECIAL NEEDS ALLIANCE Membership Has Its Benefits!

- » SNA website offering unparalleled exposure and publicity to your firm at no additional cost
- » Members-only website with access to extensive online library
- » Registration fees at outstanding educational programs is included in membership dues
- » A built-in network of your peers
- » Access to a robust SNA Listserv
- » Strong advocacy and public policy efforts
- » E-Publications reaching thousands of subscribers

"My membership in the Special Needs Alliance has been one of the most rewarding of my career. From its advocacy efforts at the national level and its ongoing educational efforts for our membership and for families who are facing a myriad of disability related concerns, the access, information, and collegiality is unmatched.

– Tara Anne Pleat, CELA

Interested in learning more about how to become a member of the Special Needs Alliance? Contact Jihane Davidow at **jihane@specialneedsalliance.org**

www.specialneedsalliance.org

Special needs require Special*Care*.

When you're ready, we're here to help. MassMutual's SpecialCare program provides access to information, specialists and financial products and services to help families facing the financial responsibilities of raising a child with a disability or other special needs. To learn more about how a financial professional can help your family, visit MassMutual.com/SpecialCare.

Insurance. Retirement. Planning.

MassMutual SpecialCare℠

GET YOUR PRACTICE *DIALED IN*

Letha S. McDowell, CELA
ELDER LAW PLANNING™
Author/Advisor

Stephen J. Silverberg, CELA, CAP
ELDER LAW PLANNING™
Author/Advisor

Natalie B. Choate
InterActive Legal
Advisor

Scott Solkoff
InterActive Legal
Advisor

WITH ELDER LAW EXPERTISE FROM

InterActive Legal

Interactivelegal.com

Discover the Advocacy Trust advantage through a comprehensive platform tailored for trust clients, plaintiff attorneys, and their clients. Offering personalized attention and expert guidance, Advocacy Trust navigates the complexities of financial planning with precision and care. Whether focusing on immediate needs or long-term goals, Advocacy Trust delivers customized solutions and steadfast support at every stage of the financial journey, ensuring peace of mind and financial confidence.

- SPECIAL NEEDS TRUSTS
- SETTLEMENT TRUSTS
- ASSET PROTECTION TRUSTS
- FIDUCIARY SERVICES
- ADMINISTRATIVE SERVICES

ADVOCACYTRUST.COM 855-879-3436

We appreciate our exhibitors for their continuous support of Stetson Law and the National Conference on Special Needs Planning and Special Needs Trusts

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

Things to Know About
Long-Term Supports and Services

STETSON LAW

Center for Elder Justice

Access and Justice For All®

Elizabeth A. Moran, JD
Executive Director
The Arc of Colorado
emoran@thearcofco.org
720.660.9794

The Arc
For people with intellectual and developmental disabilities

Health Medicaid Advocates Access Choice Quality Life Disability & Long-term Providers

STETSON LAW

Things to Know About Long-Term Services and Supports (LTSS):

What *are* LTSS?
***Who* is entitled to them?**
How do you get them?
The impact of COVID on LTSS.

Friday, November 8, 2024
11:15am – 12:05pm

Stetson's 2024
National Conference on
Special Needs Planning &
Special Needs Trusts
~
St. Petersburg Beach, FL
November 2024

1

Our Pledge…

The Arc Colorado

"…with **liberty** and **justice** for ***all***."

2

LTSS is a broad term for a variety of paid and unpaid services that help people with disabilities or chronic conditions live independently.

This can include:

- ✓Personal care assistance, such as help with eating, bathing, dressing, using the toilet, grooming, walking, cooking, etc.
- ✓Home health aide services, & taking meds
- ✓Adult daycare programs
- ✓Transportation
- ✓Supported employment
- ✓Financial management services

What *are* Long-Term Services and Supports?

The Arc Colorado

3

Who is entitled to LTSS?

People who require assistance with daily living activities due to:

Aging
Chronic illness
Disability

4

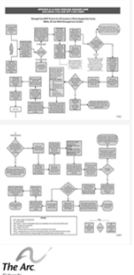
How do you get LTSS?

Medicaid policies to determine eligibility for LTSS focuses on:

- ✓ Finances (income and assets)
- ✓ Measures of functional status
- ✓ Institutional
- ✓ Home and Community-Based Services (HCBS)

5

Eligibility



Income and assets

Individuals must meet financial eligibility criteria, which can include asset limits. For example, seniors typically need to meet asset limits at SSI levels ($2,000 for an individual and $3,000 for a couple).

Functional status

Individuals must meet functional eligibility criteria, which can include being able to perform activities of daily living. States use functional assessment tools to determine an applicant's functional needs.

Other factors

Other factors that can affect eligibility include age, gender, socioeconomic status, and living arrangement.

6

Pathways to Eligibility…

- ❑ Poverty
- ❑ Medical Need
- ❑ Special income-level
- ❑ Katie Beckett pathway
- ❑ Section 1915(i)
- ❑ Medicaid buy-in
- ❑ Exceptions to prevent impoverishment (kinda)

The Arc Colorado

7

IMPACT of COVID on LTSS…

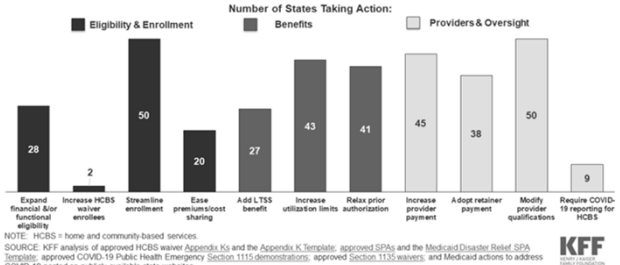
- Nursing Homes
- Tele-health & Technology
- LTSS Workforce
- Access to Services
- Rate Increases for Nursing Facilities
- Presumptive eligibility for LTSS
- Waiving Signatures
- Flexibility for Respite Care

The Arc Colorado

8

Figure 1

Medicaid Long-Term Services and Supports State Emergency Actions in Response to COVID-19, as of August 21, 2020



NOTE: HCBS = home and community-based services.

SOURCE: KFF analysis of approved HCBS waiver Appendix Ks and the Appendix K Template; approved SPAs and the Medicaid Disaster Relief SPA Template; approved COVID-19 Public Health Emergency Section 1115 demonstrations; approved Section 1135 waivers; and Medicaid actions to address COVID-19 posted on publicly available state websites.

KFF

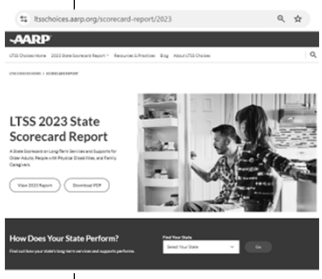
9

What we know about *who* is using LTSS

- ✓ Nearly 6 million people receive Medicaid long-term services and supports (LTSS) for assistance with activities of daily living
- ✓ Institutional settings such as nursing facilities (1.6 million people)
- ✓ In people's homes and the community (4.2 million people)
- ✓ Over half (56%) of Medicaid enrollees who use LTSS broadly are under 65
- ✓ Most enrollees who use Medicaid HCBS are under age 65
- ✓ Most enrollees who use institutional LTSS are ages 65 and older
- ✓ Just over half (51%) of all Medicaid enrollees who use LTSS are White, 19% are Black, and 14% are Hispanic
- ✓ Over two-thirds (70%) of enrollees who use LTSS and are under 65 qualify for Medicaid because of a disability

The Arc Colorado

10



https://ltsschoices.aarp.org/scorecard-report/2023

11

11

How to Report a Violation of LTSS…

- ✓Contact the Long-Term Care Ombudsman Program (LTCOP) in your area
- ✓Contact the Long-Term Care Ombudsman CRISISline: (800) 231-4024.
- ✓Contact your local police or sheriff's department.

The Arc Colorado 12

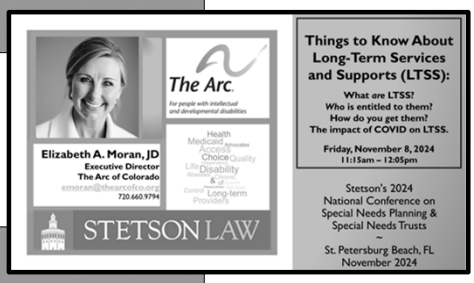
12

RESOURCES

- **10 Things About Long-Term Services and Supports (LTSS)**, Kaiser Family Foundation (KFF), Priya Chidambaram and Alice Burns, Jul 08, 2024 | https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/
- **National Inventory of Self-Directed Long-Term Services and Supports Programs |** https://ltsschoices.aarp.org/resources-and-practices/national-inventory-of-self-directed-long-term-services-and-supports-programs
- **Long-Term Care Ombudsman FAQ**, ACL. Gov | https://acl.gov/programs/long-term-care-ombudsman/long-term-care-ombudsman-faq

The Arc Colorado

13



THANK YOU!

The Arc Colorado

14


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

Government Benefits and its Role in Paying for LTSS

STETSON LAW

Center for Elder Justice

Access and Justice For All®

Government Benefits and Its Role in Paying for Long-term Care Supports and Services

LTSS Boot Camp

Stetson University National Conference on Special Needs Planning and Special Needs Trusts

October 16, 2024

Christopher W. Smith
Chalgian & Tripp Law Office, PLLC
Southfield, Michigan
(248) 799-2711
smith@mielderlaw.com

GOVERNMENT BENEFITS AND ITS ROLE IN PAYING FOR LONG-TERM CARE SUPPORTS AND SERVICES

CHRISTOPHER W. SMITH
CHALGIAN & TRIPP LAW OFFICES, PLLC
SOUTHFIELD, MICHIGAN

I. OVERVIEW

A. WHY IS THIS SO COMPLICATED?

In theory, access to government-funded long-term supports and services is simple – "get Medicaid." But while getting Medicaid sounds simple, it is anything but. Why is it so complicated?

- **Medicaid is both a federal and state program**. Medicaid's "original" sin is that it is a federal and state system. While the federal government creates the general rules and provides over half the funding, each state administers its own Medicaid program and is allowed significant flexibility in its rules and administration. Unlike Medicare, which is easy to talk about nationally, Medicaid has so much variation state by state that it is difficult to discuss at a national conference.

  Assume that everything said about Medicaid at this conference comes with the caveat: Check your state's rules and programs.

- **States, through their state plans and waivers, are given wide flexibility in their Medicaid programs**. Depending on the federal authority, states use various combinations of state plan amendments and waivers to deliver home and community-based services.

  A Medicaid State Plan is the formal agreement between a state and the federal government outlining how the state administers its Medicaid program. For our purposes,

state plan amendments under § 1915(i) Home and Community-Based Services and §1915(k) Community First Choice Option are the most common.

In our field, Medicaid waivers are utilized frequently to design programs to allow our clients to live outside institutional settings. The most common waivers for our clients are §1915(c) Home and Community-Based Services (HCBS) Waivers, §1915(b) Managed Care Waivers, and §1115 Demonstration Waivers.

States get federal approval for the financial eligibility requirements for their Medicaid programs through state plan amendments and waivers. It can be very helpful to read your state's waiver applications. Attached as Appendix 1 is Michigan's waiver application for its Habilitation and Supports Waiver 1915(c). Looking at this waiver application can be very helpful in understanding many of the concepts discussed below.

- **You cannot assume your state will follow the federal minimum guidelines**. While most states must be no more restrictive than the minimum SSI guidelines in their Medicaid financial eligibility requirements, it is frighteningly common for states to make up their own rules and dare advocates to challenge them. Because initial legal challenges usually occur through the state administrative system, the cost is rarely worth the fight, and states get by with breaking the rules.

- **Everything is political**. You must look no further back than the fight over Medicare expansion as part of Obamacare to understand that politics enters every part of Medicaid. Politics is why states have so much flexibility in Medicaid programs, and politics is almost always a key driver of each state's decision for its eligibility requirements.

In fairness to each state, on average, Medicaid expenditures are significant constituting an average of $20,644 per person with disabilities in 2021. But this can range from $49,015 in Minnesota to $10,838 in Tennessee.[1]

B. STATES HAVE GREAT FLEXIBILITY IN THEIR FINANCIAL ELIGIBILITY REQUIREMENTS.

On December 7, 2021, the Centers for Medicare and Medicaid Services issued a letter to State Medicaid Directors entitled "State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services" (included as Appendix 2). The letter emphasized that because of the Sustaining Excellence in Medicaid Act of 2019, states have great flexibility in determining income and resource disregards for individuals eligible for, or seeking coverage under, certain Medicaid authorities like sections 1915(c), (i), (k), and 1115. This option allows states to raise income and resource standards for HCBS recipients through state plan amendments and waivers. The goal is greater flexibility should help states rebalance their Medicaid programs from institutional to community-based care.

As states submit waivers and plan amendments under State Medicaid Director Letter (SMD #21-004), we can assume there will be even greater differences in the financial eligibility requirements for HCBS services between states.

II. SSI MEDICAID

A. SSI ELIGIBILITY EQUALS MEDICAID ELIGIBILITY IN MOST STATES.

In most states, SSI eligibility means Medicaid eligibility. But even here there is some variation.

[1] CMS Medicaid and CHIP 2023 Scorecard located at: https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222021%22%5D.

- **Section 1634 States**. Section 1634 of the Social Security Act (42 USC §1383c(a)) allows states to enter into agreements with the Social Security Administration (SSA), where SSA will determine eligibility for medical assistance. In these "1634 States," if an individual is eligible for $1 of Supplemental Security Income (SSI), that individual is automatically qualified for Medicaid in that state. If a client resides in a 1634 state, you should look if the individual is eligible for SSI and, if so, apply for SSI with the Social Security Administration. Once the individual has SSI, there will be no need for a separate Medicaid application.

  ***36 states are currently 1634 States: Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming*.**

- **SSI Criteria States**. In SSI Criteria States, SSI eligibility should equate to Medicaid eligibility, but the state manages their own Medicaid eligibility processes. So while a client who is SSI eligible should get Medicaid, you may be required to file a separate Medicaid application in SSI Criteria States.

  ***6 states are currently SSI Criteria States: Alaska, Idaho, Kansas, Nevada, Oregon, and Utah*.**
  POMS SI 07145.010(A)(1).

Section 209(b) States. Section 209(b) (42 U.S.C. §1396a(f)) allows states to use more restrictive eligibility criteria for Medicaid than those used for the Supplemental Security Income (SSI) program. In 209(b) States, SSI eligibility does not equate to automatic Medicaid eligibility. While Medicaid financial eligibility standards may be more restrictive in 209(b) states, clients must still have some way to "spenddown" income on

medical expenses to become eligible for Medicaid. This is called a Medicaid spenddown or, in some states, a Medicaid deductible. Thus, if you are in a Section 209(b) State, you must also know your state's specific Medicaid financial eligibility requirements.

> ***8 states are currently 209(b) States: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia*.** **POMS SI 07145.010(A)(1).**

B. GETTING SUPPLEMENTAL SECURITY ELIGIBILITY.

Again, one dollar ($1.00) of Supplemental Security Income equals automatic eligibility for Medicaid.

i. <u>Medical Eligibility</u>.

Social Security uses a five-step process for disability criteria, summarized here from attorney Avram Sacks' materials for last year's Stetson SSA Mechanics Boot Camp:[2]

1. Substantial Gainful Activity (SGA):

- The claimant must not be engaged in substantial gainful activity. In 2024, substantial gainful activity is $1,550/month, which is increased to $2,590/month for blind individuals.
- If earnings exceed the monthly threshold, the claim is denied, unless there are special circumstances (e.g., impairment-related work expenses, special accommodations).

2. Severity of Impairment:

- The claimant must have a severe impairment that significantly limits their ability to perform basic work tasks (e.g., walking, sitting, lifting, etc.).
- Minor health issues do not qualify. The combined impact of all impairments is considered.

[2] *See* Avram Sacks, The Nuts and Bolts of SSI and SSDI, Stetson Law 2023 SSA Mechanics Boot Camp.

3. Listed Impairment:

- The claimant may qualify if their impairment matches or equals a listed impairment in Social Security regulations at https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm.

- If an impairment does not meet the exact listing criteria, it can still be considered equivalent if its medical significance is similar.

4. Past Relevant Work (PRW):

- If the claim is not established by this stage, the claimant must prove they cannot perform any past relevant work done in the last 15 years.

- This includes both full-time and part-time work that meets the SGA level.

5. Vocational Adjustment to Other Work:

- If the claimant cannot perform past relevant work, the determination shifts to whether they can adjust to other work given their age, education, and residual functional capacity (RFC).

- At step 5, the burden of proof shifts to the Social Security Administration to demonstrate that the claimant can perform other jobs.

ii. <u>Income Eligibility</u>.

The SSA assesses all income types, but treats earned and unearned income differently:

- **Earned Income**. For earned income, meaning income earned while working, Social Security excludes the first $20 a month, plus disregards an additional $65 of the earned income. Then Social Security counts only half of the remaining earned income.

  Example: John has $1,000 a month in *earned* income. He would still get $485.50 in SSI calculated as follows:

  1. **Earned income:** $1,000
  2. **Apply the $20 general income exclusion** (which applies to both earned and unearned income):
     - $1,000 - $20 = $980
  3. **Apply the $65 *earned* income exclusion**:
     - $980 - $65 = $915
  4. **Divide the remaining income by 2** (since only half of earned income counts):
     - $915 ÷ 2 = $457.50
  5. **Subtract the countable income from the federal benefit rate**:

- In 2024, the SSI federal benefit rate for an individual is $943.
- $943 - $457.50 = $485.50 (John's SSI payment)

- **Unearned Income**. Unearned income includes gifts, annuities and pensions, inheritances, dividends from investments, rental income, child or spousal support, and so forth. Unearned income reduces SSI benefits dollar-for-dollar. Social Security's table of contents on unearned income can be found at POMS SI 00830.000 Unearned Income.

Example: John has $1,000 a month in *unearned* income. He would be ineligible for Supplemental Security Income calculated as follows:

1. **Unearned income:** $1,000
2. **Apply the $20 general income exclusion**:
   - $1,000 - $20 = $980
3. **Subtract the countable income from the federal benefit rate**:
   - In 2024, the SSI federal benefit rate for an individual is $914.
   - $943 - $980 = $0 (since the countable unearned income exceeds the federal benefit rate).

Importantly, Social Security Retirement and Disability benefits are considered unearned income. It is quite common for our clients to have some non-SSI Social Security and SSI as long as their non-SSI Social Security is under $963 ($943 federal benefit rate + $20 income disregard.) This can be a terrific situation for a client because this will not only entitle a client to automatic Medicaid eligibility in most states, but will make the client eligible for Medicare.

Cash distributions from a special needs trust will also count as unearned income for SSI purposes, which is a common mistake.

iii. <u>Asset Eligibility</u>.

To qualify for SSI, individuals must have countable under $2,000 for an individual and $3,000 for a couple. Countable resources include cash, bank accounts, stocks, bonds, and real estate. It does not include certain resources such as the individual's primary residence, one vehicle,

personal belongings, certain funeral expenses, ABLE Accounts, and certain special needs trusts. A full list of exempt resources is discussed in Section V, Strategies for Asset Eligibility below. .

III. NON-SSI MEDICAID

A. COMMON MEDICAID INCOME ELIGIBILITY TERMS.

To make income rules even more confusing, many income levels are set at either a percentage of the Federal Benefit Rate (FBR) *or* the Federal Poverty Level (FPL).

- **Federal Poverty Level**. The Federal Poverty Level (FPL) is calculated each year by the Department of Health and Human Services using data provided by the Census Bureau. Income limits for numerous Medicaid programs are determined as percentage of the FPL. The FPL is uniform throughout the 48 continuous states, but are different in Alaska and Hawaii. **For the 48 continuous state, the federal poverty level is $1,255/month in 2024.**

- **Federal Benefit Rate**. The Federal Benefit Rate (FBR) is the maximum monthly Supplemental Security Income benefit. Each year, increases to the FBR are tied to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), the same index used for all Social Security benefits. Historically, the FBR typically runs at about 75% of the Federal Poverty Level (discussed above), but the FBR is not technically keyed to the FPL. **In 2024, the FBR is $943/month for individuals and $1,415/month for couples.**

- **Medically Needy Income Level (a.k.a., Protected Income Level)**. For medically needy programs, the Medically Needy Income Level "is the amount remaining after spend-down

that permits an individual to qualify for Medicaid."[3] In Michigan, this is called the protected income level and can vary by geography depending on where you live in the state (and has not been changed in over 40 years). For illustrative purposes, if the Medically Needy Income Limit is $500 and an individual's income is $1,500, the individual will have to spenddown $1,000 in medical expenses in a given month before being eligible for Medicaid.

B. NON-SSI MEDICAID CATEGORIES

If a client is not eligible for SSI, the client might still be eligible for Medicaid through other financial eligibility criteria. However, it would be impossible to talk about all the Medicaid categories and each state's eligibility criteria for each category in an hour presentation.[4] Understanding some general financial eligibility criteria that states generally use when applying for Medicaid waivers can be very helpful in understanding your own state's Medicaid eligibility criteria.

For example, I have included in Appendix 4 a sample from my law firm and select passages from Michigan's operations manual to demonstrate how complicated navigating all the Medicaid programs is in just one sample state.

- **Other "Categorically Needy" Financial Criteria**. A client with a disability is "categorically needy" if the client meets income and asset limits set by the state. A categorically eligible beneficiary is automatically eligible for Medicaid without a spenddown. As discussed above, an SSI recipient is "categorically needy" in most states.

[3] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

[4] Kaiser Family Foundation has several useful resources for state-by-state comparisons.

However, states can use financial criteria more generous than SSI for categorical eligibility. Eligibility will vary by state. In these states, that more "generous" income eligibility level is usually set at 100% of the federal poverty level (currently $1,255/month), which is $312/month higher than SSI.

According to the Kaiser Family Foundation, in 2018, 20 states allowed Medicaid eligibility for seniors and people with disabilities up to 100% of the Federal Poverty Level (FPL). These states include Arizona, Arkansas, California, the District of Columbia (DC), Florida, Hawaii, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia. While Arkansas, Florida, and Virginia extend Medicaid eligibility, they do not elect the full 100% FPL. Additionally, Arkansas extends coverage beyond SSI limits for seniors only.[5]

- **Medically Needy**. States can create an optional "medically needy" Medicaid category where an individual's income is otherwise too high for categorically needy coverage. Instead, "these individuals qualify for coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy populations do not have to offer the same benefit package to them as they offer to the categorically needy."[6] An individual qualifies for Medicaid in a medically needy category after "spending down" their income on certain medical expenses below the medically needy income level in a given state.

Medically Needy Eligibility occurs when Income – Medical Expenses < Medically Needy Income Level.

[5] Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings From A 50-State Survey (June 14, 2019).

[6] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

According to the Kaiser Family Foundation, in 2018, 32 states have medically needy programs for individuals with disabilities. These states include Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.[7]

- **Special Income Group ("300% of SSI Group")**. This category is for individuals needing home- and community-based services who would otherwise require institutional care but have too much income to qualify to be categorically eligible for Medicaid. There is no spenddown for this group. States can have lower income rates, but most every state with the program has capped income at 300% of SSI (i.e., the federal benefit rate). In 2024, this is $2,829/month.

The Special Income Rule is most commonly applied to home- and community-based programs targeted at keeping older adults who would otherwise be in a nursing home at home. However, as advocates, it is sometimes important to remind agencies that individuals with disabilities may qualify for Medicaid services under numerous categories. This can sometimes be problematic, however, as the agencies charged with providing services to older adults are often different than the agencies charged with providing services to individuals with disabilities. Coordinating between those different agencies can be a nightmare. To address this, Michigan just released a letter explaining how that coordination should work, which is included as Appendix 3.

- **Adult Disabled Child (formerly DAC) Medicaid Disregard**. Under 42 USC §1383c(c), states must disregard any increase in Social Security benefits in determining Medicaid eligibility when a child transfers from being an SSI recipient to receiving adult disabled child benefits on a parent's Social Security record.

[7] Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings From A 50-State Survey (June 14, 2019).

Depending on the state, this can be highly problematic if a child was never able to receive SSI because a parent died, became disabled, retired, or never had a child apply for SSI. In certain states, this can cause a child to be ineligible for SSI-related Medicaid because the increase in income due to the Social Security increase is not disregarded. This is highly unfair, and the Special Needs Alliance is attempting to make a legislative change. Other common issues can occur when a child works and loses the ADC benefit and when a child receiving the ADC benefit gets married.

- **Medicaid Buy-In Programs**. If a beneficiary has earned income (i.e., income from working), they may be eligible for a Medicaid Buy-In program. These programs typically have higher Medicaid asset and income limits to encourage individuals with disabilities to work and may require participants to pay premiums or cost-sharing based on their income. These return to work programs can vary significantly from state to state (if available at all).

***The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4*. Only six states do not have some sort of buy-in program for individuals with disabilities: Alabama, Hawaii, Missouri, Oklahoma, South Carolina, Tennessee.[8]**

IV. STRATEGIES FOR OBTAINING INCOME ELIGIBILITY

Clients over the income eligibility limits are typically much more difficult than clients over the asset limits (which is discussed in next Section V below). But there still can be successful strategies.

[8] *Id.*

- **Can you irrevocably assign income to a special needs trust?**

In any case involving excess income, your first question should be if the income can be irrevocably assigned to a special needs trust – almost always a first-party (d)(4)(A) trust. According to Social Security POMS SI 01120.200(G)(1)(d):

> **Assignment of income**
>
> A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, unless an SSI income exclusion applies or the assignment is irrevocable. We consider assignment of payment by court orders to be irrevocable. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income. Also, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable. For more information on SPB annuities, see SI 01120.201J.1.e.

Irrevocable assignment of income to a first-party special needs trust must be done before age 65. POMS SI 01120.203(B)(3). Whether you can assign income to a pooled trust at age 65 or over is a state and specific pooled trust question.

Assigning income to an ABLE Account generally will not work because the individual owns the ABLE Account. As such, for income purposes, it is usually treated the same as if the income hit the individual's bank account.

Common examples of income that is regularly irrevocably assigned to special needs trusts:

- **Child or spousal support** *court ordered* to be paid to the SNT.
- **Survivor Benefit Plans** through the military (made possible by the 2015 Howard P. "Buck" McKeon National Defense Authorization Act thanks to many attendees of this conference).
- **Annuities**, particularly structured settlement annuities, that are irrevocably assigned by court order.

Pension assignment is a state-by-state, pension-by-pension question. The Special Needs Alliance is working with various states to promote legislation that will allow government pensions to be assigned to a special needs trust. If you want to work on this issue in your state, please e-mail me.

The Social Security POMS are also very explicit as to what *cannot be assigned*. The following cannot be assigned:

- Temporary Assistance to Needy Families (TANF)/Aid to Families with Dependent Children (AFDC);
- Railroad Retirement Board-administered pensions;
- Veterans' pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security Title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. § 1056(d)).

It will almost always be better to assign income to a special needs trust rather than using a Miller Trust if you can. You can use the trust money is many more ways to improve the client's quality of life.

- **Is a Miller Trust an option in your state and the Medicaid program you need?**

A Miller Trust (also known as a Qualified Income Trust or Income Assignment Trust) is a trust used in certain income cap states if an individual's income is above the income cap. This is the (d)(4)(B) trust if you were ever wondering why special needs trusts jump from (d)(4)(A) to (d)(4)(C)!

With a Miller Trust, if an individual's income exceeds the income cap, the additional funds can be deposited into the Miller Trust. The Miller Trust then can generally only be used to pay medical expenses not covered by Medicaid, and upon the individual's death must be paid over to the state's Medicaid agency.

Before you embark on using a Miller Trust, you must understand your state's rules regarding Miller Trusts!

According to the Kaiser Family Foundation, in 2018, 22 state allow the use of Miller Trusts for individuals with disabilities who need Home and Community-Based

Services (HCBS) under Medicaid: Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, and Texas.

- **Can the client work enough to get into your state's buy-in program with higher income/asset limits?**

As mentioned above, the Kaiser Family Foundation indicates that forty-four states have a Medicaid buy-in program for individuals with disabilities, which usually comes with higher income/assets limits. If your client can work – sometimes just a few hours – you may be able to get Medicaid eligibility even with higher incomes.

In Michigan, the buy-in program has been extremely useful in getting around the otherwise draconian and burdensome spenddowns that come with medically needy eligibility.

If you think a client working could be a pathway to eligibility, but there is no obvious employment, consider working with a disability organization (e.g., a local Arc) to see if they would be willing to hire for the minimum work required.

- **Advocate or move to another state?**

As discussed above, CMS is giving states extreme flexibility to adjust their income limits for home and community-based services. It is an ideal time to advocate for higher limits in your state.

And yes, a client could always establish residency in another state with higher income limits.

V. STRATEGIES FOR OBTAINING ASSET ELIGIBILITY

Depending on your state, the following is a checklist of options to consider if a client is above assets for Medicaid eligibility.

- **Are these services available in a non-asset tested Medicaid program?**

While this might have limited value in seeking long-term care and support services, it is worth noting that due to Medicaid expansion and the Affordable Care Act, many state Medicaid programs now use only a modified adjusted gross income (MAGI) test, without considering assets. These MAGI-only programs can encompass Medicaid expansion, children's Medicaid, coverage for pregnant women, parents and caretaker relatives, and the CHIP program. As always, the availability of these programs will vary from state to state.

> ***An individual will generally not be eligible for MAGI-based Medicaid programs if the individual has Medicare.***

- **For inheritances, evaluate whether there is a way to convert first-party money to third-party money. See if you can decant the trust if there is problematic language.**

If a beneficiary received an inheritance and there are significant assets to justify doing so, scour any will or trust for boilerplate language that might allow the inheritance to be considered third-party funds. If boilerplate language in the will or trust gives the trustee or executor authority to apply a discretionary standard to a beneficiary with a disability, utilize that language.

If the language of the trust contains problematic language or the use of the boilerplate clause might cause issues, know your state's decanting statute (if any). Often, you can decant the trust into a trust that will be acceptable to your state Medicaid agency.

Decanting is a handy tool if you have a discretionary trust drafted out of state with problematic language for your state.

Finally, remember that probate courts are generally courts of equity. As courts of equity, probate courts can sometimes use their equitable powers to fix a missed beneficiary designation or correct problematic trust provisions. This is particularly true if the settlors' intent is known, and nobody will object to the requested change.

You must do a cost-benefit evaluation before you go to court. First, know your probate court and state agency to know if this is possible relief. Second, particularly if the client is under age 65 and the sum is modest, the cost-benefit could weigh towards doing a first-party trust and avoiding the expense of court.

- **Can you convert countable resources to exempt resources?**

Particularly for small sums, you should determine if you can easily convert countable resources to exempt resources.

Below is a list of some of the major categories of exempt assets for SSI purposes. **Despite this list, there are *huge* variations from state to state**. You must know your state's rules and policy manual. Also, remember this does not need to apply for Section 209(b) States.

Start here:

- Paying down debt!

Exempt resources as found in POMS SI 01110.210:

- Home serving as the principal place of residence, including associated land (SI 01130.100). Note: There is an equity limit for long-term care Medicaid and home and community-based waivers, but not for SSI or other Medicaid categories. The equity limit will vary in each state.
- Jointly-owned real property that cannot be sold without undue hardship to other owners (SI 01130.130)
- Real property while reasonable efforts to sell it are unsuccessful (SI 01130.140)

- Restricted, allotted Indian land (SI 01130.150)
- One vehicle used for transportation (SI 01130.200)
- Burial space or plot for eligible individuals and their family (SI 01130.400)
- Household goods and personal effects (SI 01130.430)
- Stock held by native Alaskans in Alaska regional or village corporations (SI 01120.105)
- Dedicated accounts for benefits (SI 01130.601)
- Radiation Exposure Compensation Trust Fund payments (SI 01130.680)
- German reparations payments to Holocaust survivors (SI 00830.710, SI 01130.610)
- Austrian social insurance payments (SI 00830.715, SI 01130.615)
- Japanese-American and Aleutian restitution payments (SI 00830.720)
- Federal disaster assistance (SI 00830.620, SI 01130.620)
- Agent Orange settlement payments (SI 00830.730, SI 01130.660)
- Ricky Ray Hemophilia Relief Fund payments (SI 01130.695)
- Payments to Veterans' Children with Certain Birth Defects (SI 01130.681)
- State annuities for certain veterans (SI 01130.662)
- Funds in an ABLE account (SI 01130.740). As noted below, there is a $100,000 cap for SSI purposes, but no cap for Medicaid eligibility.

Exclusions with Limits on Value/Length of Time.

- Funds from the sale of a home, if reinvested in a replacement home within 3 full calendar months. (SI 01130.110)
- Life insurance up to $1,500 face. If over $1,500 face and then the cash value surrender value is counted. pending on face value (SI 01130.300)
- Burial funds for an individual and/or their spouse (SI 01130.410)
- Certain prepaid burial contracts (SI 01130.420)
- Property essential to self-support (SI 01130.500–SI 01130.504)

- Resources of a blind or disabled person necessary to fulfill a Plan for Achieving Self-Support (PASS) (SI 00870.000, SI 01130.510)
- Retained retroactive SSI or RSDI benefits for 9 months (SI 01130.600)
- Restitution payments for misused Title II, VIII, or XVI benefits (SI 01130.602)
- Cash and in-kind replacement for lost, damaged, or stolen excluded resources (SI 00815.200, SI 01130.630)
- Victims' compensation payments (SI 00830.660, SI 01130.665)
- State or local relocation assistance payments (SI 00830.655, SI 01130.670)
- Tax refunds related to Earned Income Tax Credits (SI 00830.060, SI 01130.676)
- Grants, Scholarships, Fellowships, and Gifts (SI 01130.455)

Again, despite the POMS's straightforward language on these exemptions, states put their spin on these exempt assets. While in most SSI states, you could have legal challenges if your state applies a stricter standard, it is a rare client who would want to take up that challenge – particularly if there are other avenues for Medicaid qualification.

Certain retirement assets may be exempt depending on your state and program. This is a topic that is too complicated for this presentation. Again, know your state.

- **First-Party Special Needs Trust under 42 USC § 1396p(d)(4)(A)?**

A first-party special needs trust is a standalone trust established under 42 U.S.C. § 1396p(d)(4)(A). Assets in a first-party special needs trust are exempt for Medicaid purposes. To be exempt, a first-party special needs trust must:

- Be established for individuals with disabilities *under* the age of 65;
- A parent, grandparent, legal guardian, or a court must set it up; and
- Must contain a payback clause whereupon after the beneficiary's death, the remaining assets are used to reimburse any state that provided Medicaid benefits to the beneficiary before any were received.

In many, if not most states, Medicaid paybacks cover Medicaid expenditures back to the beneficiary's birth, not the date the Trust was established. Thus, for a critically ill individual (particularly one receiving Medicare), some consideration should be given to whether establishing a trust with a payback makes sense.

Pros of a First-Party Special Needs Trust:

- A beneficiary, or the beneficiary's family, can choose the Trustee, which will often be more responsive to the beneficiary's needs and have lower ongoing administration costs.
- Trustees can also choose investment advisors and will have a wider range of investment options.
- More individualized drafting opportunities.
- Better able to manage non-cash assets.
- Allows for customized residuary distributions if residuary funds exceed a Medicaid payback.

Cons of a First-Party Special Needs Trust

- Legal fees for drafting the Trust can be expensive, and administration can be expensive if using a professional trustee.
- First-party special needs trusts tend to get frequently scrutinized by government agencies, sometimes years (or decades) later.
- Trust administration can be too complicated for an unsophisticated (e.g., family member) Trustee.
- Investment diversification may be difficult with smaller trust sizes.

 Pooled Trust under 42 USC 1396p(d)(4)(C)?

A pooled trust under 42 U.S.C. § 1396p(d)(4)(C) is the traditional alternative to a first-party special needs trust. Each beneficiary has a separate account in a pooled trust, though funds are pooled for investment purposes. A pooled trust must:

- Be managed by a nonprofit association.

- The account must be set up for the sole benefit of an individual with disabilities under Social Security's meaning.

- Remaining funds upon the beneficiary's death must either be retained by the nonprofit by the nonprofit or go to pay back Medicaid for the beneficiary's Medicaid expenditures.

> ***States and even individual pooled trusts vary in their rules regarding retained funds. In some states, pooled trusts can retain all remaining funds after a beneficiary's death, while other states require at least some percentage of the funds to go to the state for a Medicaid payback. Pooled trusts also vary in their policies as to whether a beneficiary can designate where funds go if the Medicaid lien is less than the subaccount amount.***

> ***Under 42 USC § 1396p(d)(4)(C) there is no age limit for funding a pooled trust. Yet there is significant variation among states as to whether funding a pooled trust at age 65 or over will incur a divestment penalty. But when we are talking about Medicaid programs for individuals with disabilities, many of these programs do not have divestment penalties. Funding a pooled trust at age 65 and over may be a viable strategy, but must be done with considerable care.***

Pros of a Pooled Trust

- Professionally managed by a nonprofit, which should be adept at advising on government benefits.

- Cost-effective to set up, particularly for smaller trusts.

- Economies of scale allow for greater investment diversification.

Cons of a Pooled Trust

- Limited control over distribution and investment decisions. A pooled trust's bureaucratic requirements can be frustratingly burdensome for some individuals.

- Pooled trusts vary significantly in quality.

- Ongoing administration fees can be surprisingly expensive.

ABLE Accounts?

An ABLE (Achieving a Better Life Experience) account is an exempt resource for Medicaid eligibility. An ABLE account allows the individual (if competent) to remain in control of the funds, and the funds in the ABLE Account will grow tax-free if used for qualifying disability

expenses. The disability must have begun before age 26 (to be increased to 46 in 2026). ABLE accounts may have a Medicaid payback requirement upon the beneficiary's death, although current enforcement of Medicaid paybacks varies significantly by state. Contributions to an ABLE Account are limited to the annual gift tax exclusion, which is $18,000 in 2024.

A first-party special needs and pooled trust can contribute to an ABLE account. For competent trust beneficiaries who can manage their assets but need Medicaid, special needs trusts regularly contributing to ABLE accounts can significantly lower trust administration costs and promote independence.

Remember, the disability must have simply begun before the age of 26 (46 in 2026), and you can use a doctor's certification to certify this if you do not have a Social Security Disability determination before these ages.

Pros of ABLE Accounts

- ABLE accounts offer the most independence for beneficiaries. A competent beneficiary can maintain control of their own money by managing their own ABLE account.
- ABLE Accounts are cheap, with annual fees usually $60 or under and investment fees usually around .3-.6%. This is far cheaper than pooled trusts.
- Practically, most any expenditure can qualify as a qualified disability expense. Additionally, distributions made from an ABLE account do not count as in-kind support and maintenance (ISM) for SSI.
- ABLE accounts grow tax-free if distributions are made for qualified disability expenses. This is comparable to a Roth IRA.
- Like pooled trusts, ABLE accounts allow for greater investment diversification for small sums of money.
- You can use an ABLE account in any state giving you a variety of programs to choose from (although significant consolidation of ABLE programs is occurring).
- Most ABLE programs use a TrueLink or similar type debit card, and the cost for the card is usually significantly cheaper than getting a card through a special needs trust.

Cons of ABLE Accounts

- ABLE accounts are only available to beneficiaries whose disabilities began before age 26 (46 is 2026).

- ABLE accounts are not a good option if a beneficiary is a spendthrift or vulnerable to exploitation.
- The $18,000 annual limit makes ABLE accounts a limited option for most resource planning.
- As ABLE account administrators face tight budgets, customer service with certain ABLE programs can be spotty, and many are increasingly difficult to work with, particularly for legal representatives.
- Consolidation of state ABLE programs is limiting the variety of ABLE programs to choose from.
- ABLE accounts can only handle cash.

An ABLE account is exempt for SSI purposes up to $100,000, but there is no asset limit for Medicaid purposes. In these instances, an individual is not supposed to lose SSI eligibility – SSI benefits are suspended. But be careful – this is likely a ripe area for agency error.

Is a Medicaid Buy-In Program an option?

As discussed with income above, Medicaid Buy-In Programs allow people to maintain Medicaid while working. These programs typically have asset limits (and other asset rules) that are more generous than SSI's. Thus, if your client can work at least some, that could give them a greater asset cushion.[9]

Again, in many states, the amount of work does not have to be substantial. It can be as low as a few hours a month in Michigan.

[9] The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4.

- **Does it make sense to divest assets as a last resort option?**

While this would usually be the last option to consider, many Medicaid waiver programs for individuals with disabilities may not have a divestment penalty. It could be a risky last resort option.

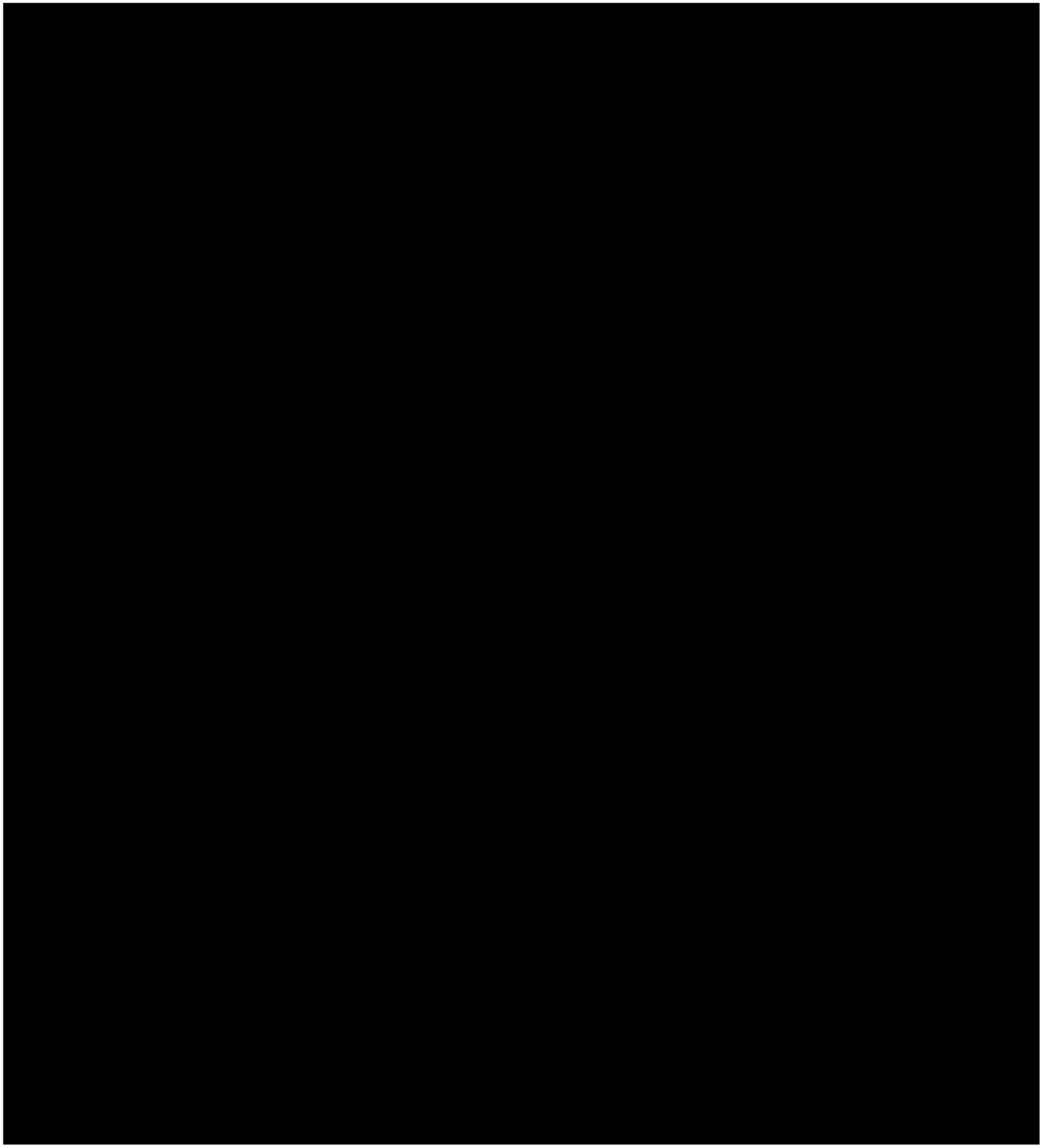
You must check your state's waiver and plan before advising. And, of course, SSI has a 3-year divestment penalty, Home and Community-Based Services 1915(c) Waivers have a 5-year divestment penalty, and HUD Housing generally has a 2-year divestment rule. So even if a current Medicaid program does not have a divestment penalty, a client may need a Medicaid service in the future where a divestment would apply.

> ***In addition to this being a last resort option, it is clearly an option you never want to take with someone with little or questionable capacity without getting court approval.***

- **Move to California?**

This is mostly facetious, but a main point of this presentation is the wide flexibility that states now have in setting financial eligibility criteria for home and community-based services. California went so far as to eliminate any asset test for its Medi-Cal program. Thus, while it is probably not practical, another last resort option could be establishing residency in a different state.

APPENDIX 1



Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Parents & caretaker relatives
42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Pregnant Women
42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Infants and Children
42 CFR 435.118
1902(a)(10)(A)(i)(III)(IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- (●) **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ( ) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - [ ] **A special income level equal to:**

      Select one:

      - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
      - ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage: [ ]
      - ( ) **A dollar amount which is lower than 300%.**

        Specify dollar amount: [ ]
    - [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
    - [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
    - [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
    - [ ] **Aged and disabled individuals who have income at:**

      Select one:

      - ( ) **100% of FPL**

APPENDIX 2

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 21-004

RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services

December 7, 2021

Dear State Medicaid Director:

This letter provides guidance to states on a "rule of construction" of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, which has been included in several subsequent federal laws (hereafter the "construction rule").[1] The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community-based services (HCBS) authorized under section 1915(c), (i), (k) and 1115 authorities.[2]

This new option permits states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals. The option affords states with broad discretion in selecting the cohorts of individuals needing HCBS for whom the state will apply higher effective income or resource standards. States could, for example, effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a particular 1915(i) or 1915(k) benefit approved under a state's plan, or for individuals eligible for one or more of the eligibility groups covered under a state's section 1915(c) waiver. This option presents states with a critical tool to use in their efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS)

[1] *See* The Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(b). CMS does not interpret the construction rule in these provisions or the Sustaining Excellence in Medicaid Act rule of construction provision to be time-limited, notwithstanding its inclusion in multiple federal laws.

[2] The construction rule in the Sustaining Excellence in Medicaid Act provision and in the provisions described in footnote 1 reads: "Nothing in section 2404 of Public Law 111-148, section 1902(a)(17) or 1924 of the Social Security Act shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (including a disregard of the income or resources of such individual's spouse); or (2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

from institutional to community-based care. The purpose of this letter is to provide information on how states can utilize the construction rule to expand coverage of HCBS under their Medicaid programs.

Background

In order to understand the new flexibility under the construction rule to expand eligibility for individuals seeking HCBS, it is helpful to review certain requirements and state options regarding the financial methodologies applied in determining eligibility for individuals seeking Medicaid based on their need for long term services and supports, eligibility groups for individuals seeking coverage of HCBS, and spousal impoverishment protections for married individuals receiving institutional care or HCBS.

Section 1902(r)(2)-based disregard authority

Section 1902 of the Social Security Act (the Act) contains two broad mandates for state Medicaid agencies in their determinations of financial eligibility for individuals who are excepted from the use of modified adjusted gross income (MAGI) methodologies.[3] First, section 1902(a)(17) of the Act requires that states use comparable financial methodologies in determining eligibility for categorical populations (e.g., individuals who are 65 years old and older, 21 years old or younger, or who have disabilities).[4] Second, section 1902(r)(2)(A) of the Act requires that states use financial methodologies in Medicaid that are no more restrictive than those applied in the most closely related cash assistance program.[5] However, section 1902(r)(2)(A) of the Act allows states to adopt income and/or resource methodologies which are less restrictive than the applicable cash assistance program. Typically, less restrictive methodologies adopted by states involve disregarding a certain amount or type of income or resources in determining applicants' and beneficiaries' countable income or resources.

CMS regulations implementing the states' authority to apply less restrictive methodologies than the corresponding cash assistance program's methodologies under section 1902(r)(2)(A) of the

[3] Section 1902(e)(14)(A) of the Act requires that states use MAGI-based methodologies in determining financial eligibility for Medicaid, subject to the exceptions described in subparagraph (D) of the same provision. Populations excepted from MAGI-based methodologies generally include, but are not limited to, individuals who seek Medicaid on the basis of being 65 years old or older, or having blindness or a disability, individuals who seek coverage for long-term services and supports, and individuals who seek Medicaid on the basis of being "medically needy." *See* 42 C.F.R. §435.603(j).

[4] *See* section 1905(a).

[5] Certain states have elected the authority provided under section 1902(f) of the Act to apply financial methodologies more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. *See* 42 C.F.R. §435.121. These states are referred to as "209(b)" states, after the provision of the Social Security Act Amendments of 1972, Pub. L. No. 92-603, section 209(b), which enacted what became codified at 1902(f) of the Act.

Act require that such less restrictive methodologies be comparable for all individuals in an eligibility group, consistent with section 1902(a)(17) of the Act.[6] In other words, targeting disregards at selected individuals in the same group is not permitted. For example, if a state elects to disregard $100 in income for individuals seeking coverage under an eligibility group for individuals 65 years old and older, $100 must be disregarded in determining the income eligibility of all 65 and older individuals applying for the group.[7]

Individuals eligible for the "217" group

In operating HCBS programs authorized under section 1915(c) of the Act, states commonly extend eligibility to individuals described in section 1902(a)(10)(A)(ii)(VI) of the Act. This section authorizes Medicaid coverage for individuals who: would be eligible for Medicaid if they were in a medical institution; would require an institutional level of care in the absence of the provision of HCBS; and will receive 1915(c) services. This eligibility group is further described in 42 C.F.R. §435.217 and is commonly referred to as the "217 group."

Determining whether the 217 group applicants satisfy the requirement in section 1902(a)(10)(A)(ii)(VI) of the Act that they "would be eligible . . . if they were in a medical institution" involves the hypothetical assumption that the applicant *is* in an institution and the concomitant identification of an eligibility group under which the individual would be eligible under the state's plan assuming such institutional status.[8] Treating a 217 group applicant as institutionalized can facilitate eligibility because: (1) the income standards of eligibility groups for institutionalized individuals covered under a state's plan may be higher than those serving noninstitutionalized individuals; and (2) the income and resources of other individuals (i.e., a spouse or parent) are not included in an institutionalized individual's eligibility determination.[9]

In order to adopt a 217 group, the state selects a group that is already covered under the state plan. We refer to this group as the "principal group." The principal group is identified in the state's section 1915(c) waiver. [10] In evaluating an applicant's financial eligibility for the 217 group, his or her income and resources are determined based on the hypothetical assumption that the applicant is institutionalized and then compared to the income and resource standards of the principal group.

---

[6] *See* 42 C.F.R. § 435.601(d)(4).
[7] Id.
[8] *See* 50 F.R. 10013, 10016-17 (March 13, 1985).
[9] Id., at 10020-21.
[10] "CMS Application for a §1915(c) Home and Community-Based Waiver [Version 3.5, Includes Changes Implemented through November 2014], Instructions, Technical Guide, and Review Criteria," pages 81-83 (Release Date: January 2015).

For example, many states that cover the 217 group also cover the "special income level group" (the SIL group) for institutionalized individuals, described in section 1902(a)(10)(A)(ii)(V) of the Act and 42 C.F.R. § 435.236. States establish the income eligibility for the SIL group, which may be up to 300 percent of the supplemental security income federal benefit rate (SSI FBR) ($2,382 a month in 2021).[11] This means that, for an individual seeking Medicaid through the 217 group in a state that: (1) has selected the SIL group as the principal group in its section 1915(c) waiver, and (2) has elected an income standard of 300 percent of the SSI FBR for the SIL group, the individual can have income up to 300 percent of the SSI FBR and be income-eligible for the 217 group (as the individual would be income-eligible under the principal SIL group if institutionalized). If the individual meets the other eligibility requirements for coverage under the 217 group (e.g., meets the level of care defined by the state and resource standard), then the individual can receive HCBS covered under the state's 1915(c) waiver.

Historically, CMS has required that states use not only the same income and resource standards of the principal group to determine eligibility for a 217 group applicant, but the same financial methodologies as well.[12] In practice, this has meant that states have applied section 1902(r)(2)-authorized disregards to the 217 group only to the extent that the same disregards are applied in determining eligibility for the principal group.

The spousal impoverishment rules

Section 1924 of the Act, commonly referred to as the "spousal impoverishment statute," requires that financial eligibility determinations for "institutionalized" spouses be determined consistent with the spousal impoverishment statute's methodology. Section 1924(h)(1) of the Act defines an "institutionalized spouse" as a married individual who is in a medical institution or, at state option, is eligible for the 217 group, and is married to an individual who is not in a medical institution or nursing facility. However, section 2404 of the Affordable Care Act (ACA), as amended by the Consolidated Appropriations Act, 2021, P.L. 116-260,[13] requires that section 1924(h)(1)'s definition of an "institutionalized spouse" include, through September 30, 2023, married individuals who are in need of HCBS authorized under section 1915(c), (i), or (k) of the Act, or a comparable package of HCBS available under section 1115 authority.

The spousal impoverishment statute generally ensures that the "community spouse" of an institutionalized beneficiary is permitted to keep a share of the couple's combined income and resources to meet the individual's own community needs, up to certain maximum standards established under section 1924(c) of the Act. In determining the amount of the couple's combined resources to set aside for a community spouse (referred to as the "community spouse resource allowance," or CSRA), the spousal impoverishment statute requires that all resources

[11] Sections 1902(a)(10)(A)(ii)(V) and 1903(f)(4)(B) of the Act.
[12] *See* 50 F.R., at 10021.
[13] *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(a) ("Extension of the spousal impoverishment protections").

owned by either spouse, jointly or solely, be pooled. The CSRA is then subtracted from this amount and the remainder is deemed to be available to the institutionalized spouse and counted in determining whether the value of his or her resources is at or below the resource standard for eligibility.

Targeting disregards on the basis of need for certain HCBS

The construction rule directs that nothing in certain statutory provisions, including section 1902(a)(17) of the Act, "shall be construed as prohibiting a state from applying an income or resource disregard" under the authority of section 1902(r)(2)(A) of the Act "on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

As described above, CMS's regulation implementing section 1902(r)(2)(A) of the Act requires that income and resource disregards adopted by a state must be comparable for (i.e., applied to all) individuals seeking coverage under a given eligibility group. CMS interprets the construction rule to create a narrow exception to that rule, such that states may target income and resource disregards at individuals within an eligibility group based on their need for certain HCBS described in sections 1915(c), (d), (i) and (k) or authorized under a section 1115 demonstration.

For example, if a state covers the optional categorically needy eligibility group authorized in section 1902(a)(10)(A)(ii)(X) of the Act, which serves individuals who have incomes up to the federal poverty level (FPL) and who are either 65 years old or older or have disabilities ("FPL group for individuals age 65 and older or who have a disability"), a state could apply an income and/or resource disregard in determining financial eligibility for the group exclusively to those individuals 65 or older who have a need for 1915(c), (i), or (k) services, or HCBS authorized under a section 1115 demonstration. Similarly, in a state that covers the medically needy, as authorized in section 1902(a)(10)(C) of the Act, the state could target an income or resource disregard at all prospective medically needy individuals who need the HCBS described in the construction rule, or even more narrowly at medically needy individuals who need HCBS and who are, for example, 65 years old and older, or under the age of 21.

CMS also interprets the construction rule to permit states to target a disregard based on an individual's need for a particular HCBS. For example, in a state that operates a 1915(c) waiver and also offers coverage for both 1915(i) and (k) services, the state could limit application of the disregard to individuals who need 1915(i) services. Furthermore, if a state operates multiple 1915(i) benefits, it could choose to apply a disregard exclusively for individuals who need one of the 1915(i) benefits. We also note that CMS has long permitted states to disregard types of income or resources, income or resources used or set aside for a particular purpose, or the

income and resources of a spouse. Per the construction rule, such disregards also may be targeted to individuals receiving HCBS or particular HCBS.[14]

We note that the construction rule refers to an individual's "need" for HCBS available under various authorities. Generally, CMS would consider it reasonable for a state to define "need" in terms of satisfying the eligibility requirements for these services; i.e., based on an individual meeting the level-of-care and coverage criteria applicable to the relevant HCBS. In the context of 1915(c) services, however, an individual's eligibility to receive such services is contingent not only on the individual meeting the level of care and coverage eligibility criteria, but also on the availability of a slot in the relevant 1915(c) waiver. It would be permissible for states to target a disregard at individuals who need 1915(c) services; i.e., individuals who meet the level-of-care and coverage criteria for a 1915(c) waiver, but may not be enrolled in and receiving those services because of a waiting list for available waiver slots.

For example, in a state that covers the 217 group in a 1915(c) waiver and uses the SIL group as the principal group (and has selected 300 percent of the SSI FBR as the income standard), an individual who meets the financial eligibility requirements for the 217 group and the clinical and coverage requirements for the waiver is ineligible for Medicaid so long as the individual is on a waiting list for the waiver and is not eligible under a separate group. This is because, as noted above, an eligibility requirement for the 217 group is that the individual will receive 1915(c) services; i.e., that there is a slot in a 1915(c) waiver in which the individual will be placed and through which the individual will receive coverage for 1915(c) services that have been included in an individual's approved plan of care.

However, an individual could still qualify for Medicaid coverage under certain circumstances. Specifically, if a state separately covers under its state plan the FPL group for individuals age 65 and older or who have a disability and elect to apply to this group, under the authority of the construction rule, an income disregard above the FPL and below 300 percent of the SSI FBR for all individuals who meet the level-of-care criteria for the relevant 1915(c) waiver. In this instance, individuals who meet such criteria but are on the waiting list for the 1915(c) waiver and who otherwise would be eligible under the 217 group can alternatively qualify for Medicaid in the FPL group for individuals age 65 and older or who have a disability and will receive coverage for other state plan services, possibly including home health care services, personal care services, and 1915(i) services (if otherwise available under the state plan) while the individual is on the waiting list for the 1915(c) waiver.

Targeting less restrictive income and resource disregards at the 217 group

[14] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 6, 7.

As noted above, CMS has historically required states to apply section 1902(r)(2)-authorized disregards to the 217 group to the same extent they are applied in determining eligibility for the principal group.[15] However, the construction rule directs that nothing in sections 1902(a)(17) or 1924 of the Act or section 2404 of the ACA shall be construed to prohibit a state from applying income or resource disregards to an individual "described in section 1902(a)(10)(A)(ii)(VI) of the Act" (i.e., the 217 group) or such individual's spouse.

Section 1902(r)(2) of the Act authorizes states to apply income or resource disregards to, among others, individuals described in section 1902(a)(10)(A)(ii) of the Act, of which the 217 group is a part. Furthermore, the implementing regulation at 42 CFR 435.601(d)(1)(ii) authorizes the use of less restrictive income and resource methodologies to "[o]ptional categorically needy individuals under groups established under . . . section 1902(a)(10)(A)(ii) of the Act." Neither the statute nor regulation limit application of income or resource disregards in determining eligibility for the 217 group.[16] While it has been the historical CMS policy to limit less restrictive methodologies for the 217 group to the extent of their application to the principal group, this policy was not mandated by the plain language of section 1902(r)(2) of the Act.

While neither sections 1902(a)(17) nor 1924 of the Act have imposed a barrier on a state's targeting of income or resource disregards at the 217 group, we interpret the specific reference in the construction rule regarding the use of section 1902(r)(2)-based disregards and the 217 group to confirm the states' authority to do so. Accordingly, states may now apply less restrictive methodologies, including income and resource disregards, exclusively to individuals seeking eligibility for a 217 group, even if such less restrictive methodologies are not applied to the principal group for which the individual would be eligible if living in an institution.[17]

As noted above, the language in the construction rule relating to the 217 group specifically references the "disregard of the income or resources of [the 217 group enrollee's] spouse." Generally, the income and resources of other third parties are not deemed available to (and therefore would have no need under the authority of section 1902(r)(2) of the Act to be disregarded for) 217 group applicants and enrollees. However, where a married individual who is a 217 group applicant or enrollee is considered an "institutionalized spouse,"[18] as defined under section 1924(h)(1), states must include the community spouse's resources in the married 217 group applicant's financial eligibility determination, consistent with the resource eligibility

[15] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 22.
[16] 42 C.F.R. § 435.601(d)(1)(ii).
[17] Disregards that apply to a principal group will continue to apply to the 217 group. As noted further in this letter, states will need to submit state plan amendments to exercise the authority provided by the rule of construction provision. However, as it relates to the 217 group, such amendments will only be necessary for disregards that states wish to target exclusively at the 217 group.
[18] *See* footnote 10, above.

formula mandated by section 1924(c) of the Act.[19] In determining resource eligibility under the spousal impoverishment statute, however, for a married 217 group enrollee, CMS interprets the construction rule to permit the disregard of a community spouse's resources. In other words, in pooling the spouses' resources for a 217 group applicant or beneficiary under the spousal impoverishment rules, states can elect to disregard all or a portion of the resources of the community spouse under section 1902(r)(2)(A) of the Act.

The same outcome may now be achieved for married medically needy individuals. Prior to the ACA's mandatory application of the spousal impoverishment rules for married 1915(c) waiver participants, states could permit the spouses of medically needy 1915(c) waiver participants to keep more resources than otherwise permitted under section 1924(c) of the Act. Section 1915(c)(3) permits a waiver of section 1902(a)(10)(C)(i)(III) of the Act, which governs the income and resource methodology rules for the medically needy, and therefore permits states to apply institutional deeming rules to married individuals (i.e., not count the community spouse's income or resources) who seek to participate in 1915(c) waivers as medically needy.[20]

Thus, before the ACA's enactment, if a married individual seeking section 1915(c) services as a medically needy individual in a 1915(c) waiver in which section 1902(a)(10)(C)(iii) of the Act had been waived, only the resources (and income) in the name of the married applicant would be included in his or her financial eligibility determination; resources exclusively in the other spouse's name, even if in total exceeding the CSRA, would not be deemed available to the married applicant.

However, by mandatory application of the spousal impoverishment rules, the resource eligibility determination requires that all of the resources owned by either spouse, separately or jointly, be pooled, and the amount exceeding the CSRA deemed available to the "institutionalized" spouse. CMS is aware that a few states preferred the pre-ACA method of effectively permitting a couple to keep all resources when one spouse needs 1915(c) waiver services, but that options for accomplishing this have generally been unavailable, with both the ACA's spousal impoverishment provision being in effect and there being no exceptions to the comparability mandate in a state's use of 1902(r)(2)-based disregards. Now, however, the construction rule permits the targeting of resource (and income) disregards at married medically needy individuals who are eligible for 1915(c) (or other HCBS) services, such that states may ultimately permit such couples to keep all resources.

---

[19] Section 1924(a)(1) of the Act mandates that its provisions supersede other provisions of the Medicaid statute that are inconsistent with the former. While not relevant here, CMS has opined that section 1924 of the Act does not supersede section 1902(e)(14)(A) of the Act, which mandates the use of MAGI income methodologies for certain Medicaid eligibility populations. *See* SMDL #15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," pages 5-6.

[20] *See* 50 F.R. at 10021.

Other related provisions of federal law

As noted, the construction rule that is the subject of this letter is contained in several recently-enacted federal laws.[21] Also included as a component of this construction rule in some of these federal laws, and independently in others, is additional language referring to home and community-based services and spousal-related income and asset disregards for individuals who qualify for Medicaid by reducing their income based on their incurred medical or remedial care expenses.[22] This letter does not address those provisions, and CMS continues to review their impact on program policies.

Conclusion

States that are interested in electing the new flexibility authorized by the construction rule must submit a state plan amendment in order to effectuate a new income or resource disregard. CMS is prepared to offer technical assistance to states that are interested. Questions about this letter may be directed to Gene Coffey, Technical Director, Division of Medicaid Eligibility Policy, CMCS, at Gene.Coffey@cms.hhs.gov.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

[21] *See* Footnote 1, above.

[22] *See* Medicaid Extenders Act of 2019, Pub. L. No. 116-3, Section 3(b)(1); Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, Section 2(b)(1); Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b)(2); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b)(2); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b)(2); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b)(2); Consolidated Appropriations Act, 2021 Pub. L. No. 116-260, Division H, Title II, Section 205(b)(2).

APPENDIX 3

Michigan Department of Health and Human Services
Program Policy Division PO Box 30809
Lansing MI 48909

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

September 11, 2024

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear MI Choice and Medicaid Behavioral Health Providers:

RE: Guide to Coordinate Services for Medicaid Behavioral Health and MI Choice

The purpose of this document is to clarify when Medicaid Behavioral Health services and MI Choice home and community-based waiver (MI Choice) services can and cannot be provided together. It should be used as a guide to develop a coordinated, person-centered, plan of services for individuals to ensure they get the support they need regardless of which program(s) serve them.

It is important to note, when a service is available through both the Habilitation Supports Waiver (HSW) and the Behavioral Health 1915(i) State Plan Amendment (SPA) service array, it is described in this document as a Community Mental Health (CMH) service. If someone is enrolled in the HSW, they would get services available from the HSW and could receive services from Behavioral Health 1915(i)SPA as long as the individual is enrolled, and medical necessity is met.

For more information on the requirements of any of the programs mentioned in this Letter, please refer to the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Information on Behavioral Health programs is found in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Information on the Home Help and MI Choice programs are found in their respective chapters with the program name.

Background

Michigan has several Medicaid programs that offer home and community-based services and supports that allow individuals to live in their own homes and receive assistance. These programs include Medicaid State Plan benefits and Medicaid waivers. Medicaid requires that services and supports be coordinated so there is no duplication of service.

The primary program that provides home and community-based support is the State Plan personal care program, called Home Help. This program is administered by MDHHS. An individual cannot be enrolled in a Medicaid waiver if their service and support needs can be fully met through Home Help services.

There are also several waivers that support people to live in the community. Two waivers, MI Choice and the HSW, serve individuals who could receive services and supports in an institutional setting. Additionally, the Behavioral Health 1915(i)SPA provides supports and services and serves many people who use the community mental health system.

With the exception for Home Help services described below, when someone enrolls in either waiver program, Medicaid rules require that the waiver program assure the services and supports necessary to maintain the individual in their preferred home or community-based setting are authorized without duplication.

The 1915(c) MI Choice and Habilitation Supports Waivers (HSW)

Some Medicaid beneficiaries may be eligible for both the MI Choice waiver and the HSW. These individuals must choose from which waiver to receive services and supports. An individual cannot be enrolled in or receive services from both waivers at the same time. While the array of services on the waivers is similar, it is not identical. For example, Enhanced Pharmacy is not a service through the MI Choice Waiver but is an HSW service. See the crosswalk at the end of this document for a listing of services available in each program. Please refer to the MDHHS Medicaid Provider Manual for a description of services. Individual choice may be based on the services available, access to providers, availability of a waiver slot or other unique factors. For persons who are eligible for both waivers, the waiver selected by an individual is not as important as providing clear communication that the individual must choose only one of the waivers.

The MI Choice Waiver provides home and community-based services and supports to the elderly and adults with disabilities who are otherwise eligible for nursing facility services. Twenty waiver agencies administer the MI Choice Waiver program throughout the state. To be eligible for MI Choice, applicants must meet the nursing facility level of care criteria, be eligible for Medicaid, and have a need for and agree to receive supports coordination and at least one other MI Choice service monthly. MI Choice offers expanded financial eligibility to its participants. The income limit is 300% of SSI ($2,829 per month, gross in 2024), and special asset protections for spouses apply. Persons who enroll in MI Choice do not have a spend-down. When enrolling in MI Choice, participants choose to receive MI Choice services instead of personal care available through the Home Help program.

The HSW provides support to people who have a developmental disability (a severe chronic condition attributable to a mental or physical impairment that has manifested before the age of 22 and impairs three or more major life activities), are Medicaid eligible, require and receive at least one habilitative service each month, reside in a community setting and are eligible to receive services available at an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID). The HSW is administered by Prepaid Inpatient Health Plans (PIHPs) through the community mental health system. Habilitation services under the HSW cannot duplicate services that are otherwise available to an individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973. Individuals enrolled in the HSW must have their personal care needs met through the Home Help program up to the limits of that program.

When a beneficiary requires a transition from the HSW to MI Choice or from MI Choice to the HSW the initial step is to contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. All HSW enrollments start on the first day of a month and may end on any day of a month. This is different for MI Choice. MI Choice enrollments can start on any day of the month and may end on any day of the month. The coordination of the start date and disenrollment date is essential when transitioning from one 1915(c) waiver to another.

Steps to follow to transfer between HSW and MI Choice:

1. The MI Choice waiver agency or PIHP must contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. The purpose of this contact is to provide justification for a transfer and supporting documentation for MDHHS review.
2. If the MDHHS specialist agrees that a transfer is appropriate, the MDHHS specialist for the current waiver program will contact the specialist for the receiving waiver program.
3. If the MDHHS specialist does not agree that a transfer is appropriate, they will contact the MI Choice waiver agency or PIHP to discuss their concerns and next steps.
4. To proceed with program transfer, MDHHS will coordinate a teleconference with the MI Choice waiver agency or PIHP.
5. The MDHHS specialist of the receiving program will notify the appropriate MI Choice waiver agency or PIHP of the potential transition.
6. The receiving MI Choice waiver agency or PIHP completes the evaluation of eligibility.
7. Upon confirmation of the individual's eligibility and their approval to transfer to the new program, the MI Choice waiver agency and PIHP coordinate the individual's disenrollment and enrollment dates.
8. Disenrollment from the current waiver must occur on the last day of a month, with the start date of the new waiver occurring on the 1st of the following month.
9. Once known, the disenrollment date and start date must be communicated to the MDHHS waiver specialist to ensure a smooth transition between waivers.

Coordination with the Behavioral Health 1915(i)SPA

People who are eligible for either MI Choice or HSW may be eligible for Behavioral Health1915(i)SPA and additional State Plan services available through the community mental health system. These services are available to people with intellectual disabilities, developmental disabilities, or serious mental illness. Some people with serious mental illness may be eligible for MI Choice Waiver services because of a physical disability and for Behavioral Health 1915(i)SPA services because of their serious mental illness.

MI Choice participants may receive Behavioral Health 1915(i)SPA and State Plan services that do not duplicate MI Choice services. This includes services such as Skill-Building and Supported Employment. A person with an intellectual or developmental disability or serious mental illness who is enrolled in the MI Choice Waiver could access Behavioral Health State Plan and Behavioral Health 1915(i)SPA services through the community mental health system.

Since Behavioral Health State Plan, HSW and the Behavioral Health 1915(i)SPA services are administered through the community mental health system, coordination of those services is common. Coordination of Behavioral Health State Plan and Behavioral Health1915(i)SPA services with the MI Choice waiver is more challenging since they are administered by different agencies. Such coordination involves regular communication between the two agencies. MI Choice enrollees must receive supports coordination from MI Choice as a condition of enrollment. However, it may be necessary for a MI Choice participant to also have a CMH case manager to help them access and manage the behavioral health services they require.

Coordination of CLS and Personal Care

Coordination of services and supports issues also arise for people on the HSW and people only receiving Behavioral Health 1915(i)SPA and State Plan services who need more personal care than is available through the Home Help program or other programs. The MDHHS Medicaid Provider Manual has addressed how the CLS services are coordinated with State Plan personal care services for individuals served by the mental health system:

> "For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's needs for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help."
>
> "If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision."
>
> See the MDHHS Medicaid Provider Manual for more information.

Clarification of Similar Services

- **Individual or Group Therapy (CMH service) versus Counseling (MI Choice service)**

  CMH offers Individual or Group Therapy while MI Choice offers counseling services. Individual or Group Therapy is more intense and focused on treatment whereas Counseling is less intense and focused on assisting the person with adjusting to life changes.

Individual or Group Therapy is defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Service chapter under the Covered Services section of the MDHHS Medicaid Provider Manual as:

> "Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships.
>
> Evidence based practices such as integrated dual disorder treatment for co- occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker."

Counseling is defined in the MI Choice chapter of the MDHHS Medicaid Provider Manual as:

> "Counseling services seek to improve the participant's emotional and social well- being through the resolution of personal problems or through changes in a participant's social situation. Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs."

- **Community Living Supports**

Both HSW and MI Choice offer Community Living Supports (CLS), which is also a Behavioral Health 1915(i)SPA service.[1] These services are similar in many ways, but often delivered differently because of the differing emphases among the programs. Both programs provide guidelines for the provision of the CLS services, without being too descriptive, to allow individuals some flexibility.

When both the CMH and MI Choice waiver agency are providing CLS services to the same person, it is essential to have a coordinated person-centered service plan that specifically delineates exactly what each entity is doing for the individual to avoid any duplication of services. The person-centered service plan should also describe why the service is not available from the other entity. For instance, the CMH may provide CLS that includes transportation to and from community classes as well as assistance during the class while the MI Choice waiver provides CLS in the morning to assist with bathing, dressing, and meal preparation to get the individual ready to attend the class. MI Choice cannot provide CLS during the class because skill building is not a MI Choice service.

It is also important to note that the CMH service cannot duplicate nor replace personal care services available through the Home Help Services program. Individuals enrolled in MI Choice cannot also use Home Help Services. Therefore, it may be necessary for the MI Choice program to cover services such as assistance with ADLs that would otherwise be covered through the Home Help program.

- **Services in Residential Settings**

Both the HSW and MI Choice programs can offer services in Residential Settings. According to Section 11 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the MDHHS Medicaid Provider Manual, the CMH can only authorize personal care services in a "licensed foster care setting with a specialized residential program certified by the state." MI Choice may provide services in licensed Adult Foster Care Homes or Homes for the Aged and in unlicensed Assisted Living Facilities. Section 4.1 of the MI Choice chapter of the MDHHS Medicaid Provider Manual states that services in a licensed setting "cannot be provided in circumstances in which they would duplicate services available elsewhere or are available under the State Plan." Therefore, MI Choice services are not available to persons who are being served by CMH in a specialized residential program certified by the state.

CMH provides "Personal Care in Licensed Specialized Residential Settings" and offers additional assistance to meet the ADL and IADL needs of the individual. The MI Choice program offers Community Living Supports or Residential Services to provide additional services to participants who live in a residential setting and require more services and supports than would be normally offered to a resident.

- **Environmental Modifications (Environmental Accessibility Adaptations or Home Modifications)**

The Environmental Modifications are also known as Environmental Accessibility Adaptations and Home Modifications. Regardless of the title of the service, the definitions are very similar for both CMH and MI Choice. One notable difference is that MI Choice will never cover central air conditioning, but CMH will under certain well-defined circumstances. If a participant is using the services of the CMH and those services are meeting their needs, it is not appropriate to make a referral to the MI Choice program solely because the person requires an environmental modification.

- **Respite Care Services**

The Respite Care Services definitions are very similar for both CMH and MI Choice. Both provide intermittent services to relieve a family member or other (unpaid) caregiver. The CMH will allow a licensed nurse to provide respite. In the MI Choice program, only non-licensed persons furnish respite services. If a nurse is providing services, then the service is called either Private Duty Nursing or MI Choice Nursing services. Additionally, the CMH definitions allow respite to be provided at a Licensed Camp, which is not allowed in MI Choice.'

Services that CANNOT Be Used Simultaneously

- Persons can never be enrolled in both the MI Choice Waiver program and the HSW at the same time. The process to transition from one 1915(c) waiver to another is explained above and requires careful planning and coordination.

- When respite is needed, a single agency (either the CMH or the Waiver Agency) should authorize all respite services.

- Persons living in a licensed foster care setting with a specialized residential program certified by the state cannot also enroll in the MI Choice program.

- Persons receiving CMH Therapy services should not also have MI Choice counseling services authorized. MI Choice counseling is NOT a replacement for CMH Therapy.

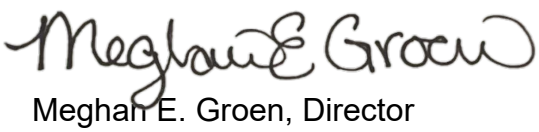
Conclusion

To ensure individuals with long-term services and supports needs can address those needs and access the full array of services and supports available, coordination between service systems is crucial. Refer to the table below to learn more about the services offered in each program. Coordination is key to implementing the individual's person-centered service plan that clearly delineates the services and supports authorized by each program or system, how those services differ from similar services available elsewhere, and why each system must furnish the services authorized. The goal is to assure individuals receive the services and supports he or she needs to have a full life in the community within each programs' requirements and parameters without duplication.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

Sincerely,



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

MI Choice, Habilitation Supports Waiver (HSW) and Behavioral Health 1915(i)SPA Crosswalk

	MI Choice 1915(c)	Habilitation Supports Waiver 1915(c)	Behavioral Health 1915(i)SPA
Program Eligibility ***Can only be enrolled in one 1915(c) Waiver at a time**	• Meets Nursing Facility Level of Care Criteria • Eligible for Medicaid (expanded eligibility rules apply) • Is either elderly (aged 65+) or aged 18 or older and has a disability. • Needs and agrees to receive at least one MI Choice service, in addition to supports coordination monthly • Resides in a home and community-based setting • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Has an intellectual or developmental disability (as defined by Michigan law) • Eligible for Medicaid • If not for HSW services, would require ICF/IID level of care services; and chooses to participate in the HSW in lieu of ICF/IID services. • Resides in a community setting • Must require and receive at least one HSW habilitative service per month • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Eligible for Medicaid • Available to beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability who are currently residing in a HCBS setting and meet the needs-based criteria. **Needs based criteria:** • Have a substantial functional limitation in one or more areas of major life activity AND • Without Behavioral Health §1915(i)SPA services, at risk of not increasing or maintain a sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, and/or community inclusion and participation.
Private Duty Nursing	Available for qualified participants aged 21+	Available for qualified adults with IID age 21+	N/A
Level of Care	Nursing Facility	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	N/A
Medicaid Health Plan Enrollment	Exempt	Exempt	Exempt

Services Requirement	Must receive at least one MI Choice waiver service in addition to supports coordination per month	Must receive one habilitative service each month. Habilitative services include the following: 1. Community Living Supports 2. Out of Home Nonvocational Habilitation 3. Prevocational Services 4. Supported Employment	Must receive at least one Behavioral Health 1915(i)SPA service every three months, in addition to monthly monitoring, as documented in the person-centered service plan
Available Services	• Adult Day Care • Assistive Technology • Chore Services • Community Health Worker • Community Living Supports • Community Transportation • Counseling • Environmental Accessibility Adaptations • Fiscal Intermediary • Goods and Services • Home Delivered Meals • Nursing Services • Personal Emergency Response System • Private Duty Nursing/Respiratory Care • Residential Services • Respite • Specialized Medical Equipment & Supplies • Supports Brokerage • Supports Coordination • Training • Vehicle Modifications	• Community Living Supports • Enhanced Medical Equipment & Supplies • Enhanced Pharmacy • Environmental Modifications • Family Training • Fiscal Intermediary • Goods and Services • Non-Family Training • Out-of-Home Nonvocational Habilitation • Overnight Health and Safety Supports • Personal Emergency Response Systems • Prevocational Services • Private Duty Nursing • Respite Care • Supports Coordination • Supported Employment	• Community Living Supports • Enhanced Pharmacy • Environmental Modifications • Family Support & Training • Fiscal Intermediary • Housing Assistance • Respite • Skill Building • Specialized Medical Equipment & Supplies • Supported/Integrated Employment • Vehicle Modification

Home Help Program	Cannot receive Home Help Services when enrolled in MI Choice. The MI Choice service of Community Living Supports will fulfill personal care service needs.	Must use Home Help (through MDHHS) as eligible.	Must use Home Help (through MDHHS) as eligible.
Other	• If aging out of State Plan private duty nursing services, usually enroll on 21st birthday. (May enroll sooner if you need MI Choice services other than private duty nursing.) • Cannot enroll before the initial assessment by a waiver agency. • Can still receive all Medicaid State Plan services including mental health services, however careful coordination must occur.	• May enroll at any age if eligibility criteria are met and a slot is available • May back-date enrollment under specific circumstances • Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination)	• Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination) • Can be enrolled in a C-Waiver and the BH 1915(i)SPA

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

APPENDIX 4

MEDICAID PROGRAM SCREENING QUESTIONS:

Who Can Qualify for Medicaid in Michigan?

	Is the person age 19-64 *and* not qualified for and not enrolled in Medicare or Medicaid with modified adjusted gross income at or below 138% of the Federal Poverty Level ($20,120 in 2023)?	If YES, eligible under the Healthy Michigan Plan BEM 137
If NO,	Is the person on SSI?	If YES, eligible under BEM 150
If NO,	Is the person a former SSI recipient who lost SSI eligibility due to receipt of or an increase in RSDI benefits in the past?	If YES, possible eligibility under BEM 155 (503 Individuals) BEM 157 (Early Widow(er)s) BEM 158 (Disabled Adult Children)
If NO,	Is the person under 65 with a disability?	If YES, possible eligibility under BEM 170 (Home Care Children) BEM 171 (Children's Waiver) BEM 174 (Freedom to Work) BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person under age 65 and blind, but with no determination of disability?	If YES, possible eligibility under BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person age 65 or over?	If YES, possible eligibility under BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")

Is the person a Medicare beneficiary who needs help paying for Medicare premiums, coinsurances and deductibles?	Possible eligibility under BEM 165 for the Medicare Savings Programs (QMB, SLMB, ALMB or NMB) or BEM 169 for Qualified Disabled Working Individuals (QDWI)

MEDICAID PROGRAM TERMINOLOGY

503 Individuals **BEM 155**	Former SSI recipients who lost SSI eligibility due to an increase in Social Security Retirement Survivors Disability Insurance (RSDI) benefits. Medicaid eligible if the person would be eligible for SSI if the RSDI cost-of-living increases paid since SSI eligibility ended were excluded.
AD-CARE **BEM 163**	People age 65 or over and people under age 65 with a disability. Net countable monthly income cannot exceed 100% of the Federal Poverty Level (in 2024, $1,275 for one person).
Children's Waiver **BEM 171**	A child under age 18 who requires care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) but can be cared for at home for less cost.
Disabled Adult Children (DAC) **BEM 158**	A person age 18 or older who received SSI and ceased to be eligible for SSI on or after July 1, 1987 because she or he became entitled to receive DAC RSI benefits or because of an increase in such RSI benefits and is currently receiving DAC RSI benefits and would be eligible for SSI without such RSI benefits.
Early Widower(s) **BEM 157**	A person entitled to Medicare Part A and who receives RSDI benefits some or all of which are early Social Security widow(er)'s benefits and was terminated from SSI because of the receipt of those benefits and was receiving SSI in the month the early widow(er)'s benefits began and would be eligible for SSI if all the widow(er)'s benefits were excluded.
Extended Care **BEM 164**	A Medicaid eligibility category available to nursing home patients and persons seeking MI Choice waiver program and PACE services who are age 65 or older or who are under age 65 and have a disability. If the person has too much income to qualify for AD-CARE, Medicaid eligibility may be secured if gross monthly countable income does not exceed 300% of the SSI Federal Benefit Rate ($2,829 in 2024).

Freedom to Work **BEM 174**	Available to a person with a disability (according to Social Security's disability standards) who is aged 16 through 64 and who is employed with earned income. The asset and income standards for eligibility are more generous than other categories of Medicaid eligibility.
Group 2 Medically Needy **BEM 166**	Available to persons age 65 or older, persons who are blind or persons with a disability who have too much countable income to qualify for other categories of Medicaid. Eligibility for Medicaid is secured in any month in which a person incurs health care costs that equal or exceed a person's excess income, *a.k.a.* "the deductible".
Healthy Michigan Plan **BEM 137**	Available to persons age 19-64 who do not qualify for and are not enrolled in Medicare or Medicaid and have a modified adjusted gross income of 138 percent of the Federal Poverty Level ($20,782 in 2023). There is no asset test.
Home Care Children **BEM 170**	Available to a child under age 18 who is unmarried and has a disability who requires institutional care but can be cared for at home for less cost.
Medicare Savings Programs **BEM 165**	Programs that pay for a Medicare beneficiary's premiums, deductibles and coinsurances. The asset limits are more generous than other Medicaid programs.
MI Choice Waiver **BEM 106**	A program for persons age 65 or older and for persons with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2024).
PACE **BEM 167**	The Program for All Inclusive Care for the Elderly. A managed care program for persons age 65 or older and for persons under age 65 with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2023).

EXHIBIT I - LIST OF SSI-RELATED MA CATEGORIES

MA Category	BEM Item	Unique Nonfinancial Eligibility Factor	Program Code	Financial Eligibility Group	Automatic MA Eligibility
SSI Recipients	150	Aged, blind or disabled	A, B, E	1	Yes
Appealing SSI Termination	150	Appealing SSI termination	M, O, P	1	No
503 Individuals	155	Aged, blind or disabled	M, O, P	1	No
Early Widow(er)s	157	Blind or disabled	O, P	1	No
DAC	158	Aged, blind or disabled	M, O, P	1	No
AD-Care	163	Aged or disabled	M, P	1	No
Extended-Care	164	Aged, blind or disabled	M, O, P	1	No
Medicare Savings Programs	165	Medicare Part A	M, O, P	-	No
Group 2 Aged, Blind and Disabled	166	Aged, blind or disabled	M, O, P	2	No
QDWI	169	Type of Medicare	P	-	No
Home Care Children	170	Disabled	P	1	No
Children's Waiver	171	Disabled	P	1	No
Breast and Cervical Cancer Prevention and Treatment Program	173	Health department cancer screening	O	1	No

EXHIBIT II - SSI-RELATED MA CODING

Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
AD-Care	163	Full QMB	0	1F	4	4
AD-Care	163	None	0	1F/1E	5	4
Extended-Care	164	Full QMB	8	1F	0	4
Extended-Care	164	Limited QMB (SLMB)	1	1F	1	4
Extended-Care	164	None	1	1F/1E	0	4
Group 2	166	Full QMB	9	2F	0	3
Group 2	166	Limited QMB (SLMB)	0	2F	2	3

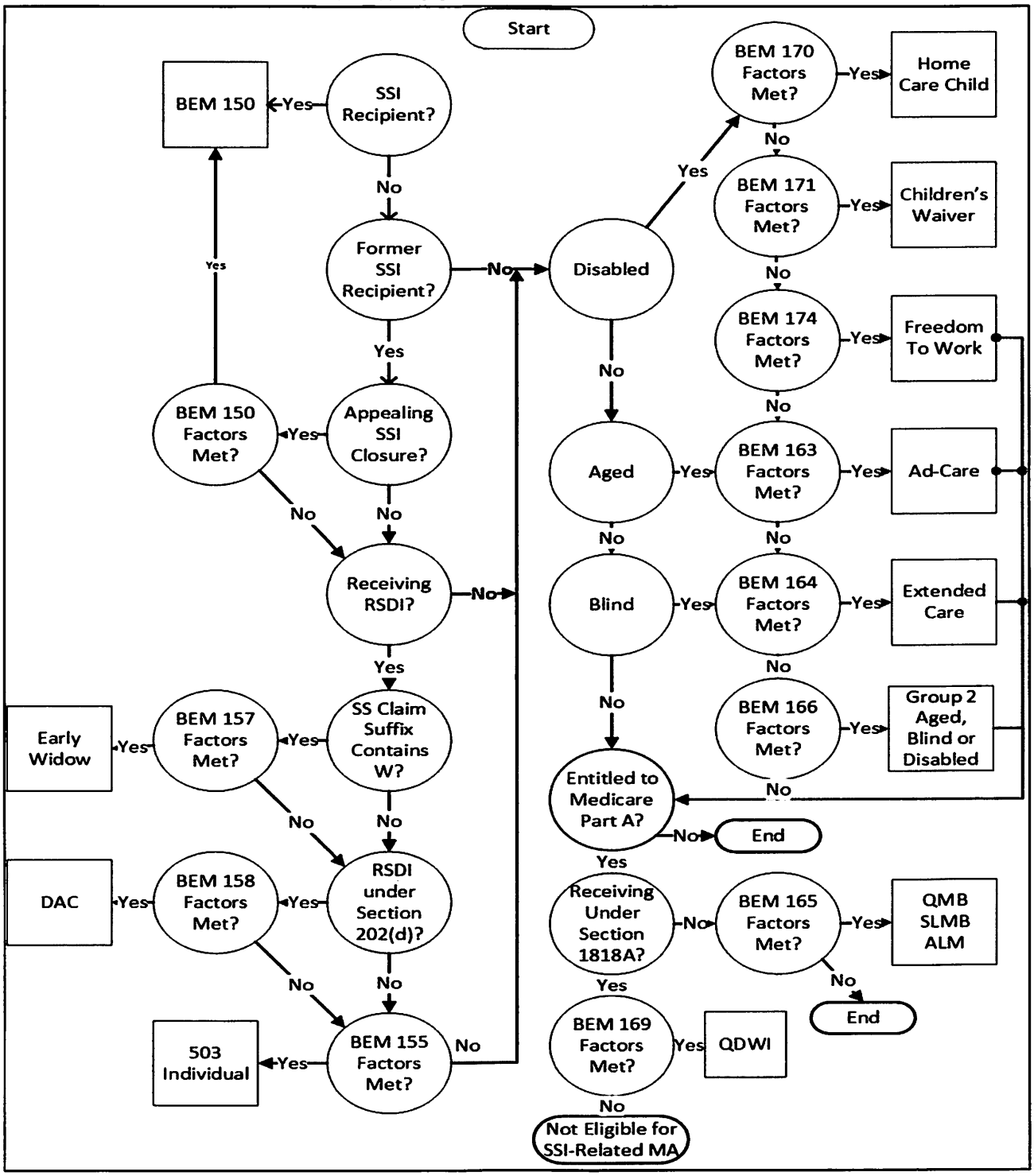
Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
Group 2	166	None	0	2F/2E	0	3
Active Deductible	545	Full QMB	9	2B	0	7
Active Deductible	545	Limited QMB (SLMB)	0	2C	2	7
Active Deductible	545	None	0	20	0	7
Active Deductible	545	Full ALMB	0	2H	0	7
None	**NA**	**Full QMB**	**9**	**2B**	**0**	**3**
None	**NA**	**Limited QMB** (SLMB)	**0**	**2C**	**2**	**3**
Appealing SSI termination	150	**	0	1F	0	4
503 Individual	**155**	**	**5**	**1F**	**0**	**4**
Early Widow(er)	**157**	**None**	**7**	**1F**	**0**	**4**
DAC	**158**	**	**4**	**1F**	**0**	**4**
Home Care Child	**170**	**	**0**	**1F**	**0**	**4**
Children's Waiver	**171**	**	**0**	**1F**	**0**	**4**
QDWI	**169**	**None**	**0**	**1Q**	**0**	**4**
Freedom to Work (FTW)	174	None	0	1D	0	4
Freedom to Work (FTW)	174	Full QMB	8	1D	0	4
Freedom to Work (FTW)	174	Limited QMB (SLMB)	0	1D	2	4
Freedom to Work (FTW) premium level	174	None	0	1K	0	4
None	NA	Full ALMB	0	2H	0	3

DATA ELEMENT KEY

- **Case level Program Type (PT) on format page one.**
- **Scope/Coverage (SC).**
- **Recipient level Program Type (PT) starting on format page two.**
- **Eligibility Status (ES).**

Note: When adding coverage to an active deductible case, the ES remains 7.

EXHIBIT I - SSI-RELATED MA CATEGORIES



LEGAL BASE

MA

CHALGIAN & TRIPP
LAW OFFICES PLLC

Government Benefits and Its Role in Paying for Long-term Care Supports and Services

Christopher W. Smith
smith@mielderlaw.com | (248) 799-2711

LTSS Boot Camp
Stetson University SNT Conference
October 16, 2024

1

Get Medicaid!

2

3

Why Is This So Complex?

- **Medicaid's Original Sin:**
  A Dual Federal / State System
- **State Flexibility Through State Plans and Waivers**
- **State's Not Doing What They Should**
- **Politics**

3

SSI = Medicaid (Mostly)

- **Section 1634 States**
- **SSI Criteria States**
- **209(b) States**

4

5

5 Steps for Social Security Medical Eligibility

1. **Substantial Gainful Activity (SGA).** 2024 = $1,550/month ($2,590/month for blind individuals).
2. **Severity of Impairment.**
3. **Listed Impairment.**
4. **Past Relevant Work (PRW).**
5. **Vocational Adjustment to Other Work.**

5

6

Earned Income and SSI

1. Earned income	$1,000
2. Apply the $20 general income exclusion	-$20 $980
3. Apply the $65 earned income exclusion	-$65 $915
4. Divide the remaining income by 2	÷ 2 $457.50
5. Subtract countable income from the federal benefit rate	$943 - $457.50 = $485.50

6

7

Unearned Income and SSI

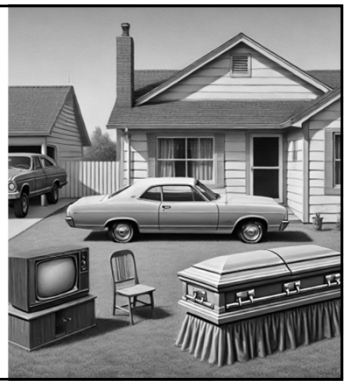
1. Earned income — $1,000
2. Apply the $20 general income exclusion — -$20 = $980
3. Subtract countable income from the federal benefit rate — $943 - $980 = $0

Other Social Security Benefits = Unearned Income

7

SSI Asset Eligiblity

- $2,000 Individual
  $3,000 Couple
- Exempt Assets.



8

9

Common Medicaid Income Eligibility Terms

- **Federal Poverty Level (FPL):**
  $1,255/month in 48 states.
- **Federal Benefit Rate (FBR):**
  Maximum SSI benefit/ $943/month for individuals.
- **Medically Needy Income Level (MNIL)**
  Varies by state/geography.
  Example: Spend down $1,000 if income is $1,500 and MNIL is $500.

9

Common Non-SSI Medicaid Categories

10

11

Categorically Needy

- **No Income Spend Down.**
- **Slightly higher income limit than SSI. Usually 100% FPL / $1,255 in 2024.**
- **~20 States.**

11

12

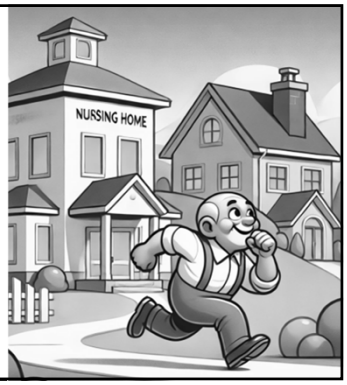
Medically Needy

- **Must spend down on medical expenses until the medically needy income level is reaches.**
- **Income – Medical Expenses < Medically Needy Income Level.**
- **~32 States.**

12

Special Income Group ("300% of SSI Group").

- **Individuals who would otherwise require institutional care.**
- **300% of the Federal Benefit Rate $2,829/month**



13

Adult Disabled Child (formerly DAC)

- **Medicaid disregards additional Social Security income when child goes from SSI to Adult Disabled Child benefits off a parent's benefit record.**

14

15

Medicaid Buy-In Programs

- **Higher Medicaid Income / Asset Limits if the individual receives *earned income.***

www.mielderlaw.com

CHALGIAN & TRIPP LAW OFFICES PLLC

15

Strategies For Obtaining Income Eligibility

www.mielderlaw.com

CHALGIAN & TRIPP LAW OFFICES PLLC

16

Can The Income Be Assigned To A Special Needs Trust?

17

- Child / Spousal Support with Court Order
- Military Survival Benefit Plans
- Annuities
- Pensions?

Assignment Must Be Irrevocable and Before Age 65 (for standalone Trust!)

www.mielderlaw.com

CHALGIAN & TRIPP LAW OFFICES PLLC

17

Is a Miller Trust and Option?

18

- aka, Qualified Income Trust.
- Available in ~22 States.
- Income in excess of income cap is put into trust.
- Payback requirement.

www.mielderlaw.com

CHALGIAN & TRIPP LAW OFFICES PLLC

18

19

Other Income Eligibility Strategies

- Can client get into buy-in program?
- Can you get creative with medical expenses in a medically needy state?
- Advocate for higher limits in your state?
- Move?

19

Strategies For Obtaining Asset Eligibility

20

21

Asset Eligibility Strategies

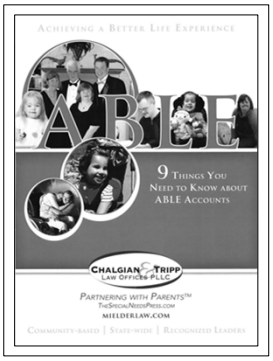
- Is there a MAGI-related Medicaid program that would work?
- Can you convert countable assets to exempt assets?
- For inheritances, is there a way to convert into 3rd Party money?

21

Special Needs Trust?

- **First-Party Standalone Special Needs Trust**
  - **Drafted by Attorneys.**
  - **Trustee / Asset Flexibility.**
- **Pooled Trusts**
  - **Managed by Nonprofits.**
  - **Professional management / investment diversification.**

22



ABLE Accounts

Pros of ABLE Accounts

- Independence/beneficiary control.
- Cheap.
- Tax-free growth.
- Investment diversification.
- Wide distribution discretion.
- Cheap TrueLink card.

Cons of ABLE Accounts

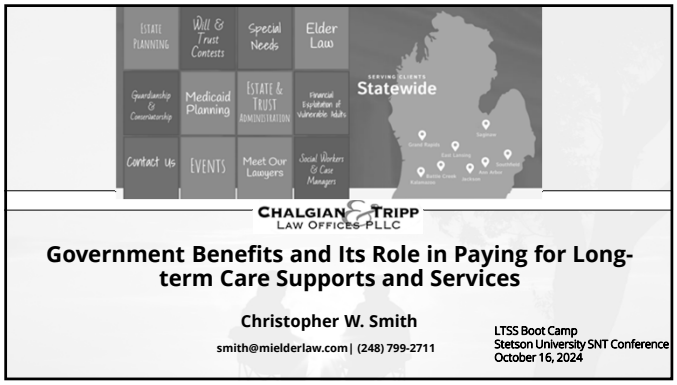
- Disability began before 26 (46 is 2026).
- The $18,000 annual limit (tied to gift tax exemption).
- Spotty customer service.
- ABLE accounts can only handle cash.

23

Other Asset Eligibility Requirements

- **Is a Medicaid Buy-In Program an option?**
- **Divest assets?**
- **Move?**

24


ESTATE PLANNING
Will & Trust Contests
Special Needs
Elder Law
Guardianship & Conservatorship
Medicaid Planning
ESTATE & TRUST ADMINISTRATION
Financial Exploitation of Vulnerable Adults
Contact Us
EVENTS
Meet Our Lawyers
Social Workers & Case Managers
SERVING CLIENTS
Statewide
CHALGIAN & TRIPP
LAW OFFICES PLLC
Government Benefits and Its Role in Paying for Long-term Care Supports and Services
Christopher W. Smith
smith@mielderlaw.com | (248) 799-2711
LTSS Boot Camp
Stetson University SNT Conference
October 16, 2024

25


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

Medicaid's Right to Reimbursement and Special Needs Trusts

STETSON LAW

Center for Elder Justice

Access and Justice For All®

2024
National Conference
on
Special Needs Planning
and
Special Needs Trusts

LTSS Boot Camp

Wednesday
October 16, 2024

Medicaid's Right to Reimbursement
and
Special Needs Trusts

by

Bridget O'Brien Swartz, J.D., M.P.A.
ACTEC Fellow

I. Introduction: Beginning at the End

When discussing special needs trusts with a client, one normally begins with distinguishing a third-party special needs trust from a first party special needs trust. Assuming the focus of the discussion is on first party special needs trusts, the foregoing would follow with the requirements to establish a first party special needs trust, one of which is to provide for reimbursement to Medicaid on termination of the trust. Although Medicaid's right to reimbursement from a first party special needs trust would no doubt be discussed with a client, it presumably would be given minimal attention. This discussion is going to instead begin with and primarily focus on all things termination as it relates to a first party special needs trust. Hopefully, at the conclusion of the discussion, one will have a greater appreciation for the importance of beginning at the end, that is, ensuring that those contemplating a first party special needs trust arrangement enter into it knowingly when it comes to what happens at the time the trust terminates.

II. In the Beginning, . . .

How can it be that first party special needs trusts were codified more than thirty years ago?! It bears reviewing the originating legislation and developments in the law that have since followed with an eye towards the language surrounding termination of these trusts and Medicaid's right to reimbursement.

A. Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

OBRA '93 carved out three critical exceptions to the newly penalized transfers into irrevocable trusts and the countability of the income and assets of such trusts pursuant to 42 U.S.C. § 1396p(d)(4), all of which require reimbursement to Medicaid on their termination as follows:

1. Under subsection (A), a "disabled under age 65" must provide that **the State will receive all amounts remaining in the trust upon the death of such individual up**

to an amount equal to the total medical assistance paid on behalf of the individual. A "disabled under age 65" trust arguably contends with reimbursement to Medicaid upon the death of the beneficiary more frequently than the other exempt trusts.

2. Under subsection (B), an "income-only or Miller" trust must provide that **the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual**. An "income-only or Miller" trust as this trust is commonly known or referred to is the least likely of the three exempt trusts to have anything remaining in the trust upon its termination.

3. Under subsection (C), a "pooled" trust must provide that, **to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.** A majority of "pooled" trusts retain some portion or all amounts remaining upon the death of the beneficiary and, as such, reimbursement to Medicaid may not be at issue or, if so, limitedly so.

B. HCFA Transmittal 64[1]

This famous transmittal of the Health Care Financing Administration ("HCFA") now Center for Medicare and Medicaid Services ("CMS") was published as guidance for State Medicaid Manual Chapter 3 Eligibility Sections 3257 to 3259.8, which sections addressed the transfer of assets and treatment of trusts post-OBRA '93. With regards to Medicaid's right to reimbursement from one of the exempt trusts established pursuant to 42 U.S.C. § 1396p(d)(4), the

[1] The State Medicaid Manual Chapter 3 Eligibility Section 3257 to Section 3259.8 | Guidance Portal (hhs.gov).

guidance of the transmittal essentially parrots the statute.

C. Foster Care Independence Act of 1999

OBRA '93 only affected eligibility for long-term care Medicaid. For the decade that followed, it was unclear whether the Supplemental Security Income ("SSI") program recognized special needs trusts. The Foster Care Independence Act of 1999[2] caught up with Medicaid by not only providing for penalties for uncompensated transfers by SSI recipients, but also adopting and mirroring the Medicaid special needs trust exceptions.[3]

D. SSA's Programs Operations Manual System (POMS)

The SI POMS has gone through many iterations when it comes to special needs trusts and termination or Medicaid payback language, with the most substantial overhaul being in 2009. As it stands, the POMS is protective of Medicaid's interests and requires a first party special needs trust to provide for repayment to the State Medicaid program all amounts remaining (but in the case of a pooled trust, only to the extent not retained by the trust) at the time of termination up to an amount equal to the total amount of medical assistance paid on behalf of the individual.[4] The POMS broadly contemplates termination of a first party special needs trust and reimbursement to Medicaid and does not limit it to time of death but at any time during the lifetime of the beneficiary.

III. First Party/Self-Settled SNT Termination Provisions

A. Early Termination Provisions

Federal Medicaid law and regulations expressly provide for reimbursement to Medicaid from a special needs trust at time of death only[5] while the SSA, as just noted, requires such a trust to also provide for reimbursement to Medicaid in the event the trust is terminated during the

[2] 42 U.S.C. § 1382b(c)(1)(A)(iv).
[33] 42 U.S.C. § 1382b(c)(1)(C)(ii)(IV).
[4] POMS SI 01120.203.B.8 and C.1.
[5] *See* 42 U.S.C. § 1396p(d)(4)(A)-(C) and HCFA Transmittal 64 at *supra* note 1.

lifetime of the beneficiary.[6] In so doing, the SSA speaks to why a special needs trust may provide for early termination, implying that these are the only permissible reasons for early termination: The beneficiary is no longer disabled or otherwise becomes ineligible for SSI and Medicaid, or the trust no longer contains enough assets to justify its continued administration.[7] As such, specifically referencing the foregoing in an early termination provision may be advisable. One must also be mindful of and include in an early termination provision of a special needs trust the limitations imposed by the POMS on the payment of administrative expenses (i.e., state and federal taxes due, reasonable fees and administration expenses associated with the termination of the trust).[8] What happens next if, after reimbursing Medicaid and paying administrative expenses as permitted, trust assets remain? They must be paid to the trust beneficiary![9]

Despite federal Medicaid law and regulations limiting Medicaid's right to reimbursement from a special needs trust to time of death, some state Medicaid programs, Arizona's for one, have gone astray in also requiring reimbursement in the event the trust is terminated during lifetime[10] and placing limitations on the payment of administrative expenses.[11] In this author's experience, which is limited to Arizona, its Medicaid program does not seek to be reimbursed from a special needs trust in the event the trust is terminated during lifetime if the beneficiary is solely eligible for Medicaid by virtue of being eligible for SSI, i.e., is categorically eligible for Medicaid,

---

[6] *See* POMS SI 01120.200.H.1.b. stating that "Medicaid trusts generally have a payback stating that upon termination of the trust, or the death of the beneficiary, the State Medicaid agency will be reimbursed . . ." and POMS SI 01120.199.E.1 that requires an early termination provision to provide for reimbursement to Medicaid.
[7] POMS SI 01120.199.
[8] *See id.*
[9] *See id.*
[10] *See* A.R.S. § 36-2934.01.A.1 which requires the trust to contain "specific language that protects the state's beneficiary interest in the trust and that names the administration or the state medicaid agency as the primary beneficiary of the trust **if the trust is terminated before or on the death of the member**."
[11] *See* A.R.S. § 36-2934.01.B.1 that limits disbursements from a special needs trust to reasonable legal and professional expenses related to the trust not just at time of termination but throughout the entirety of the administration of the trust.

but only if the beneficiary is eligible for long-term care Medicaid. The foregoing is ironic, to say the least, given the POMS's requirement to provide for reimbursement to Medicaid on early termination?!

B. Termination at Death Provisions

When it comes to termination of a special needs trust upon the death of the beneficiary, no one questions Medicaid's right to reimbursement. Again, though, limitations on payment of administrative expenses prior to such reimbursement exist[12] and, payment of expenses of last illness, funeral and burial may not be made until after Medicaid has been reimbursed.[13] In Arizona, if funeral and burial arrangements have not been made prior to the beneficiary's death, the trustee will be permitted to disburse up to but no more than $1,500 for such expenses with the prior approval of Medicaid (through its recovery agent).

If trust assets then remain, who may be the residual beneficiary? That is a loaded question. From a purely estate planning perspective, whether or not the beneficiary is or may one day be mentally capable of doing their own estate planning, preserving their ability to do so with a limited power of appointment is an option.[14] If this power is not exercised, then, presumably, the laws of intestacy will apply. If SSI eligibility is at issue for the beneficiary, a special needs trust may be presumptively revocable under state law if no residual beneficiary is named, thereby rendering the trust assets countable.[15] So, it may behoove the drafting attorney to name a residual beneficiary of a nominal interest before providing for distribution by intestacy.

---

[12] *See* POMS SI 01120.203.E,
[13] See.id¡
[14] A general power of appointment is inadvisable as it will subject it to the claims of creditors of the beneficiary's estate.
[15] *See* POMSSI 01120.200.D.3.

The question of a residual beneficiary for SSI purposes is a non-issue if Medicaid is considered the residual or contingent beneficiary. The POMS assert that, according to the law in most states, the State is not considered a residual or contingent beneficiary but, rather, a creditor and reimbursement to Medicaid is considered the payment of the debt unless the trust reflects a clear intent that the State is a beneficiary rather than a creditor.[16] Who in their right mind would name Medicaid as a beneficiary?! Probably no one except when required to do so by Medicaid, which happens to be the case in Arizona.[17]

C. When All Else Fails. . .the Power to Amend

Even the most artfully crafted termination provision is bound to fail with the SSA or Medicaid eventually given changes in the law, regulation, policy, and the winds. With that in mind, a provision that provides for the power to amend a special needs trust is recommended. To ensure that a special needs trust is not rendered countable for SSI purposes, the power to amend should belong to someone other than the beneficiary and should be limited such that the trust assets of are not considered available to the beneficiary for their maintenance and support.[18] The power to amend should not be general or broad in nature, but limited, so as not to jeopardize its status as irrevocable in the eyes of the pertinent governmental assistance programs.[19] For example, a limited power to amend could provide for amendments that ensure that the special needs trust continues to comply with the provisions of 42 U.S.C. § 1396p(d)(4), the POMS, and/or pertinent state Medicaid laws and regulations with the objective of ensuring the beneficiary remains financially eligible for public benefits or governmental assistance programs

[16] POMS SI 01120.200.H.1.b.
[17] *See* A.R.S. § 36-2934.01.A.1.
[18] *See* POMS SI 01120.D.1.a.
[19] Stating a special needs trust is "irrevocable" is not sufficient in and of itself for SSI eligibility purposes. *See* POMS SI 01120.D.e.

that are needs-based.

D. Third Party Special Needs Trusts

Keeping this short n' sweet--unless charitably inclined, do NOT provide for reimbursement to Medicaid as it is NOT required!

IV. The Nuances of Paying the Piper

No ifs, ands or buts, the time has come to pay the piper, so to speak--to at long last pay to "the State all amounts remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the [beneficiary]" of the special needs trust[20] (other than from those amounts retained by a pooled trust). If the beneficiary leaves survivors who were the beneficiary's caregivers and who may not have been compensated or compensated adequately for the care they rendered their loved one, the prospect of inheriting very little or nothing, is a harsh reality. Does no basis exist to deny Medicaid's claim for reimbursement in whole or in part?

A. Medicaid Estate Recovery

Just as OBRA '93 created exceptions for special needs trusts from the transfer penalty rules and their countability for eligibility purposes, this very law also mandated the states to institute an estate recovery program to seek to recover from the estate[21] of a Medicaid enrollee who was 55 years of age or older, at a minimum, payment for nursing facility services, home and community-based services, and related hospital and prescription drug services.[22] States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. States are also required to establish procedures for waiving estate recovery when recovery would cause an undue hardship.[23]

---

[20] *See* 42 U.S.C. § 1396p(d)(4)(A)-(C).
[21] *See* 42 U.S.C. § 1396p(b)(1)(A).
[22] *See* 42 U.S.C. § 1396p(b)(1)(B)(i).
[23] *See* 42 U.S.C. § 1396p(b)(2)(A) and (3).

The obvious question is whether the limitations on estate recovery also apply to Medicaid's right to reimbursement from a special needs trust. Unfortunately, case law has arrived at the consensus that the age limitation, survivor exemptions, and undue hardship waiver that apply to estate recovery do not to apply to a special needs trust.[24] The statutory schemes and requirements are distinct primarily in that the special needs trust exceptions allow for individuals to financially qualify for Medicaid who otherwise would not. As such, those who choose to avail themselves of a special needs trust exception are opting for that reimbursement arrangement rather than that of estate recovery.[25]

B. Pre- and Post-Establishment of Special Needs Trust

Logic would have it that the requirement to reimburse Medicaid from a special needs trust would be limited to medical assistance paid from the time the trust was established. But who says logic is at play here? To the contrary, Medicaid's right to reimbursement from a special needs trust is not limited in duration and dates back to when the beneficiary was first eligible for and receiving such medical assistance. Take the POMS, for instance, which leaves no ambiguity on this point: "Medicaid payback . . .cannot be limited to any particular period of time; for example, payback cannot be limited to the period after establishment of the trust."[26] Case law follows suit finding that 42 U.S.C. § 1396p(d)(4) does not limit the payback to a particular period of time[27] and that the State can recover an amount equal to the total medical assistance paid.[28]

---

[24] *See* Herting v. California Dept. of Health Care Services, 235 Cal.App.4th 607 (Cal. App. 2015); First Capital Sur. & Trust Co. v. Elliott, Civil Action No. 4194-VCG (Del. Ch. Sept. 2012); *see also* Gonzalez v. City National Bank, 36 Cal App.5th 734 (Cal. App. 2019).
[25] *See* Gonzalez, 36 Cal. App. 5th at 782 (*citing* Herting, 235 Cal.App.4th at 609, 614).
[26] POMS SI 01120.203.B.8. It is also in this provision that the POMS make clear that reimbursement cannot be limited to a particular state.
[27] *See* Matter of Abraham XX, 11 N.Y.3d 429 (N.Y. App. 2008); Cockrell v. Comm. of Social Security, Civ. Action 2:18-cv-1124 (S.D. Ohio 2019); *see also* First Capital Sur. & Trust Co., Civil Action No. 4194-VCG (Del. Ch. 2012).
[28] *See* Matter of Abraham XX, 11 N.Y.3d 429 (N.Y. App. 2008.

That being said, in those instances where the special needs trust is funded with a third party recovery, i.e., a personal injury settlement, consider whether a Medicaid lien[29] was paid prior to funding the special needs trust. If so, make sure that Medicaid is not double dipping in seeking to be reimbursed from the special needs trust at the time the trust terminates. In other words, the amount of the lien that was asserted by Medicaid against the third-party recovery and paid should be deducted from Medicaid's claim for reimbursement. An argument can be made that, if the lien was compromised, the amount to be deducted is not limited to what was paid but the total amount of the lien that was fully and finally satisfied by payment of the compromised amount.

C. "Medical Assistance"

So, what is included in the medical assistance for which Medicaid seeks to be reimbursed from a special needs trust at the time of its termination? "Medical assistance" is not amorphous or broadly defined but, rather, is defined as "payment of part or all of the cost of the following care and services," followed by 21 enumerated services.[30] In those states where Medicaid is a fee-for-service system, make sure the claim for reimbursement presented by Medicaid only includes the services specified under federal law. What is not included in the list are capitated payments or payments paid by Medicaid to a managed care organization if Medicaid opts to deliver services in that manner.[31]

However, in 2001, CMS updated the Medicaid Manual regarding its estate recovery provisions as it relates to managed care. Specifically, Transmittal 75 requires Medicaid to seek to recover premium payments in its claim against an estate when the Medicaid beneficiary was

[29] *See* 42 U.S.C. §§ 1396k(a)(1)(A) and 1396a(a)(25)(H).
[30] 42 U.S.C. § 1396d(a).
[31] *See* Pottsgieser v. Kizer, 906 F.2d 1319 (1990),

enrolled in a managed care organization ("MCO").[32] Transmittal 75 further requires Medicaid to provide a separate notice to the Medicaid beneficiary that explains that the premium payments made to the MCO are included in a claim against the estate.[33] Two takeaways and points of negotiating Medicaid's claim for reimbursement from a special needs trust for a beneficiary who was enrolled in a MCO are that Transmittal 75 is limited in application to estate recovery and, if separate notice of the intent to seek to recover capitated or premium payments was not given, the claim fails.[34]

V. Conclusion: Ending Where One Should Begin

Now that you know all things about termination of a first party special needs trust, which is presumably more than you care to know, let us circle back to the beginning. The beginning is when you are sitting with a client who is confronted with the question, to SNT or not to SNT. Discussion about Medicaid's right to reimbursement from a first party special needs trust is more often than not given de minimus attention. The client does not fully appreciate that termination can occur during lifetime not just at time of death, that a significant claim may already exist at the time the trust is established, what is included in "medical assistance," nor which expenses are disallowed until after Medicaid is reimbursed. With this discussion, the author hopes that the practitioner will have a greater understanding of Medicaid's right to reimbursement from a first party special needs trust, and, as such, devote the time and attention necessary to counseling clients about this oft-overlooked requirement.

[32] State Medicaid Manual, Part 3 – Eligibility, Health Care Financing Administration Pub. No. 45-3, Transmittal 75, § 3810.A.6 (Jan. 11, 2001).
[33] *See id.*
[34] *See* Executive Office of Health and Human Services v. Trocki, 100 Mass. App. Ct. 117 (2021).


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

The Intersection of
Long-Term Care and Housing

STETSON LAW

Center for Elder Justice

Access and Justice For All®

THE INTERSECTION OF LONG-TERM CARE AND HOUSING

By Blaine P. Brockman, Esq.
Darby Legal Assistance
West Jefferson, Ohio

Effective long-term care in community settings requires three essential supports; health care, financial support and housing. Like a three-legged stool, without one of these supports, everything fails. This session will give you an overview of housing programs administered by Medicaid agencies, HUD, local organizations and others in order to become comfortable advocating for long term care related housing needs.

THE INTERSECTION OF LONG-TERM CARE AND HOUSING

Blaine P. Brockman, Esq.
Darby Legal Assistance

I. GENERALLY

A. *The goal*

1. It is impossible to know everything about the programs I will address. My goal is not to make you an expert in various ways that long-term care systems support community living. I do hope to make you comfortable with the basic framework of programs that may help support housing in your community. Your job will be to use this information to "sniff out" where these programs exists and what they do.
2. Tips
    i. Build a relationship with the people in your state Medicaid administrative authority who administer Medicaid housing programs. You can find these people by simply contacting the agency and asking to talk to their housing specialists.
        a. These people are likely not running the actual housing assistance program. They are managing its funding, program compliance, etc. They probably have private or public sector contractors who run the program.
        b. Don't limit yourself to one agency. Medicaid administrative authority is often contracted from the one Medicaid state agency to various agencies based on population served. Each agency will have people who know a little (sometimes a lot) about housing programs.
    ii. Through the contacts described above, determine the local organizations that operate housing and tenant selection. These are probably your best resources. But

they will only know what is in the scope of their duties. They will not necessarily be able to discuss matters outside of their "swim lanes."

iii. Volunteer with housing organizations – typically not for profit companies. Volunteer in a way that puts you in touch with the leadership. Hint: they are almost always looking for qualified board members.

B. ***The 3-legged stool – Creating conditions that ensure successful community living.***

1. **Care**: There must be some means by which the resident can provide themselves healthcare. Without proper healthcare housing fails because the condition of the resident fails and that could impact activities of daily living critical to non-institutional care. Healthcare may include State plan (community) Medicaid, Waiver Medicaid, Medicare, Private insurance and private payment
2. **Money or funding substitute**: Successful community living requires a means of purchasing necessities like food, clothing, furnishings, travel, entertainment, etc. These things are not simply "niceties." They are essential to proper nutrition, successful employment, travel, entertainment, community engagement, etc.
3. **Shelter**: It may seem obvious that successful community living requires shelter. But there's more. Shelter must be affordable, accessible, located correctly (e.g. near public transportation, safety services, sources of food, etc.). Too often, this leg of our stool is overlooked by those seeking community integration. Unfortunately, it is often overlooked by public policy as well. It is often what fails first. For these and other reasons, this is the hardest leg to build.
4. These materials address the intersection between care and shelter.

C. ***The community housing paradigm***

1. **Stop thinking about affordable housing the way you always have.** If your first image is about towers on the edge of downtown (or in some other segregated or unappealing location), or hardened apartments along a busy road, you're a few decades behind the times. Modern, well-constructed affordable housing is often located with other, market rate housing. In fact, it is common to locate affordable housing and market rate housing in the same project or neighborhood.
2. **It's not all Section 8 housing**. Since the mid-1980's the Low-Income Housing Tax Credit (LIHTC) program has been the largest source of financing and producing affordable housing. It is not a HUD program. It is a tax program. And, while many LIHTC properties are also Section 8 properties, that is not universally the case. Additionally, the loss of a Section 8 voucher in a LIHTC property (e.g. due to income ineligibility) does not necessarily mean losing the housing. Additionally, there are many local affordable housing initiatives that have no connection to HUD or Section 8 whatsoever. You must expand the scope of your vision for affordable housing beyond Section 8. <u>However, it is likely that the agencies that operate non-HUD housing support programs are probably in contact with the local PHA and other housing providers.</u>
3. **Do not stop when you find a waiting list**. The number one thing I hear when I talk with others about affordable housing is, "The housing authority has a [*insert years here*] waiting list." However, many LIHTC properties (again, the major source of affordable housing), if they use Section 8, manage waiting lists within their own properties. The same is true for local affordable housing organizations (who own the

housing). The so called “waiting list” for such properties often is only weeks long if it exists at all. Additionally, LIHTC properties can comply with their affordability obligations without using Section 8 at all. If you stopped your search at the housing authority, you did not look far enough. I have personally helped people get Section 8 vouchers in affordable housing within 3 months.

4. **Affordable housing providers “cobble together” resources**. Because housing management is so expensive and because people who need affordable housing are also people who need help with other legs of our stool, affordable housing providers often have multiple sources of money for production and maintenance of housing. Additionally, many also assist residents in maintaining their housing. Thus, “follow the money” is an important principle in locating and maintaining successful housing. You must understand where housing resources are, who administers them, and what they contribute to successful housing. The more you understand how “housers” cobble together resources, the more successful you will be in finding and maintaining housing.

5. **Develop the ability to “sniff out” housing resources**. Housing resources (especially those that are linked to Medicaid funding) are location specific. That location could be a state, a county, a city, or township. It is common for affordable housing programs to be administered concurrently by multiple governments at all levels, non-profit and for-profit corporations, and individuals. It is not enough to contact one authority; ask a few questions and feel you have all the answers you need. You must know what these programs are, who operates them, who they serve, and how they’re funded.

With that knowledge, you can talk to multiple people and get a sense for "the smell" of a program. From there, you can apply that to your client's needs.

II. MEDICAID SUPPORTED HOUSING RELATED SERVICES[1]

A. ***This is not your mother's Medicaid***.

1. Modern considerations for healthcare are no longer driven only by volume-based considerations of care (often resulting in limitations on volume), to value base considerations of care. Value based considerations of care link nontraditional factors effecting a person's well-being to the care provided. Additionally, notions of community living have moved beyond mere access to the community, and now look at the factors that make such housing successful. Thus, the link between healthcare and community living is no longer limited to the "bricks and sticks" – it is about housing in the community as a means to address healthcare needs of the resident.

B. ***It is not just about "affordable" housing. It is about "community housing."***

1. **Two drivers of Medicaid support for housing (not just affordable housing)**

   i. The long-standing role of integration

      a. We have all become familiar with the Supreme Court's mandate that people with disabilities have a right to receive services in the community.[2] This has come to be known as the integration mandate. It is the historic foundation of many efforts to fund community support with Medicaid dollars.

   ii. Emerging role of Social Determinants of Health (SDOH)

---

[1] This these materials rely <u>*heavily*</u> on the following authorities:

- Centers for Medicare & Medicaid Services (CMS). SHO# 21-001. "*Opportunities in Medicaid and CHIP to address social determinants of health (SDOH)*." January 7, 2021.
- Medicaid and CHIP Payment and Access Commission (MACPAC), *Issue Brief: Medicaid's Role in Housing*, June 2021

[2] *Olmstead v. L.C.,* 119 S. Ct. 2176 (1999).

a. SDOH's are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." [3]

b. An emerging body of evidence shows health care is adversely effected by limited access to "nutritious food, **affordable and accessible housing**, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment."[4] [emphasis added]

c. Within the overarching principles of the Medicaid program, "State Medicaid . . . can utilize a variety of delivery approaches, benefits, and reimbursement methodologies to **improve beneficiary outcomes and lower health care costs by addressing SDOH**."[5] [emphasis added] ". . . CMS provides states with flexibility to design an array of services to address SDOH that can be tailored . . . to address state-specific policy goals and priorities, **including the movement [to[. . . value-based care** . . . " for Medicaid recipients.[6]

2. **Types of housing-related services that may be available using Medicaid[7]**

i. Temporary or permanent modifications to the home to help someone remain in the home and community. For example,

- Installing wheelchair ramps,
- Adding grab bars in the bathroom,
- Altering doorways and other passages to improve accessibility.

---

[3] The Centers for Disease Control and Prevention (CDC), *Social Determinants of Health (SDOH),* January 2024, , https://www.cdc.gov/socialdeterminants/about.html
[4] SHO# 21-001
[5] Id.at 3
[6] Id.
[7] Id. at 5

ii. Paying one-time expenses to aid in transition from an institutional setting to a community setting. For example:

- Paying security deposits,
- Purchasing essential household furnishings.

iii. Pre tenancy supports and services. For example:

- Assisting with the screening an application process,
- Making properties safe and ready for move-in,
- Paying for transportation and moving expenses.

iv. Tenancy Sustaining supports and services. For example:

- Addressing behaviors that may jeopardize housing.
- Education and training on landlord tenant rights and responsibilities,
- Individualized case management and care planning.

v. Note: Medicaid may not be used for room and board in a community setting.[8]

C. ***Specific Medicaid-funded housing resources***

1. **Money Follows the Person (MFP) Demonstration**

i. MFP provides funding for Medicaid beneficiaries, residing in a nursing home or other institutional setting for 60 consecutive days, wishing to transition from the facility to a community setting. MFP was authorized under the Deficit Reduction Act Of 2005. It has been reauthorized periodically since then and funding is currently available through fiscal year 2027.

ii. To be eligible for MFP an individual must:

a. Be enrolled in Medicaid.

[8] This is the basis for what is known as the "institutional bias" in the Medicaid program.

b. Have resided in a long-term care facility for at least 60 consecutive days.

c. Be transitioning to the community.

iii. States may have additional requirements. For example, under Ohio's HOME Choice program, the individual must:

a. Have income to sustain community living.

b. Participate in an assessment and have a need for the program.

c. Have care needs that can be met in a community setting.

2. **Medicaid Waiver Programs**[9]

i. Generally

a. *It is not important* to know the statutory waiver authority (e.g., 1915(c)). Many local authorities will not. *It is critical* to know what is available under the waiver program, to whom it is available, if it is operating in your state, and who may be administering it.

b. Medicaid waiver programs are complex, have varying degrees of availability, may be managed by multiple organizations, provide varying services, and some of the services are duplicative between waiver authorities.

ii. 1155 Demonstration Waivers

a. States may request waivers to evaluate programs that are "likely to assist in promoting the objectives of certain programs under the Act"[10] The requested waivers must be budget neutral for the federal government. Typically, 1115 waivers are initially approved for a five-year period and may be renewed beyond that.

[9] See generally, Section 1915 of the Social Security Act, and 42 § CFR Part 431 Subpart G
[10] 42 CFR § 431.404

b. States have broad discretion to target populations regardless of geographic location or health condition. States could test the effectiveness of a range of programs designed to address SDOHs. For example, Washington State's 1115 Demonstration addresses housing related services and training to address behavioral health costs, and reduce the need for more expensive interventions (i.e. emergency centers).

iii. 1915(b) Managed Care Waivers

a. Managed care programs are expanding nationwide. People receiving Medicaid under managed care programs (typically combining Medicare and Medicaid) who meet medical necessity criteria may be eligible for a variety of housing related services to address SDOH. This may include transition to a community setting as well as services necessary to sustain housing.

iv. 1915(c) Home and Community Based Services (HCBS) Waivers

a. This is likely the waiver most people are familiar with. It has broad application and is widely used to serve people having an institutional level of care. It waives the requirement for statewidedness and comparability.

b. It provides a wide range of optional services addressing SDOH to achieve community integration and maximize independence. Some of this may be only one time, i.e., at transition.

(i) Transition assistance. For example:

(a) Service coordination or case management,

(b) Installation of ramps and grab-bars,

(c) Widening of passageways,

(d) Bathroom modifications,

(e) Installation of specialized systems to support medical equipment,

(f) Paying security deposits,

(g) Purchase of essential household furnishings and window coverings,

(h) Moving expenses,

(i) Pest eradication,

(j) Home accessibility adaptations,

(k) Activities to procure other essential needed resources.

(ii) Housing and tenancy support. For example:

(a) Assessing community integration options,

(b) Assisting in securing housing, including completing applications,

(c) Assisting in communicating with the property owner regarding accommodations needed,

(d) Help to remain in community housing, such as assistance with housing recertification, and with dispute resolution with neighbors.

(iii) Habilitation services: ". . . designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and

adaptive skills necessary to reside successfully in home and community-based settings."[11] Including:

(a) Interpersonal skills training to help successfully engage the community-based housing system.

(b) Assistance in learning how to interact positively with neighbors, landlords, and others,

(c) Assisting with technology that enable a person to acquire and/or maintain employment.

(iv) Providing necessary non-medical transportation (e.g., to the grocery store).

(v) Purchasing home-delivered meals.

(vi) Aid and accessing supported employment services.

(vii) Acquiring and learning to use assistive technologies to facilitate successful community living.

v. 1915(i) Using state plan dollars for HCB services.

a. This waiver serves people who qualify under needs-based criteria and wish to reside in the community. Typically, these criteria are less stringent than institutional criteria. States have the option to target specific populations within the aged-blind-disabled (ABD) population.[12]

b. The authority here is very broad and can be used to provide any services that are available under 1915(c) waivers.

[11] See generally, § 1915(c)(5)

[12] For more detail on this authority, see CMS. SMD# 21-004, *State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services*

c. For example, Minnesota's state plan waiver covers housing stabilization services for people with disabilities who are, or are at risk of, experiencing homelessness, and individuals with a disabling mental illness, or substance use disorder.

vi. 1915(j) Self-Directed Personal Assistance Services (PAS)

a. This waiver serves people eligible for state plan PAS or any services under 1915(c) waivers. This waiver allows the Medicaid recipient to self-direct the type of services needed and negotiate provider rates and services.

b. The waiver supports many things that promote independence or are a substitute for other assistance (such as a microwave oven, grab bars, or an accessibility ramp) to the extent that it replaces expenditures for personal assistance.

c. An example of this is the Ohio Self-Empowered Life Funding (SELF) Waiver.[13]

vii. 1915(k) Community First Choice state plan

a. This waiver serves people who have an institutional level of care. It must be offered statewide (i.e., statewidedness has not been waived).

b. The waiver funds mandatory and optional services.

(1) Mandatory

(i) Personal assistance (e.g. supervision and cueing) with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks.

[13] See generally, https://dodd.ohio.gov/waivers-and-services/waivers/1-self-waiver.

(ii) Acquiring and maintaining skills necessary for the individual to accomplish ADLs and IADLs and health- related tasks.

(iii) Back-up systems so that service and support continue; and

(iv) Training on how to select and manage attendants.

(2) Optional

(i) Expenses necessary for transitioning from an institution.

(ii) Expenses necessary to increase independence.

c. For example, Connecticut's First Choice SPA provides services for transitioning from a nursing facility, institution for mental diseases, or ICF/IID and establish a household in a community setting.

3. **State Plan Services**

i. Section 1905(a) state plan services.

a. This section allows states to provide services that aid Medicaid recipients in accessing medical and social services. Since they are state plan services, they may have a distinctive look and feel from a typical waiver program. For example, they may be provided by organizations that typically provide community (or MAGI) Medicaid.[14]

b. Rehabilitative services necessary to address SDOH.

(1) For Medicaid recipients who meet the medical necessity category of eligibility, rehabilitative services may be available to regain skills and functioning to address SDOH.[15] Such services could include regaining

[14] This author has had such an experience wherein person with SMI was assisted by a state Medicaid contractor with the author nor the individual had previous contact. The referral came from a behavioral health facility following an emergency admission. She maintained Medicaid eligibility using a special needs trust.
[15] SHO# 21-001 at 11

skills necessary for finding housing, filling out paperwork, securing important documents, negotiating with property managers, and interacting with neighbors.

c. Targeted case management (TCM)

(1) TCM can be used to develop care plans that incorporate transition to, and sustaining of, community settings.

(2) Colorado added TCM services as a state plan benefit to provide case management to individuals who are transitioning from a nursing facility or ICFs/IID.

III. U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT (HUD) HOUSING

A. As housing providers "cobble together" resources, HUD housing is typically an essential consideration. The HUD eligibility rules apply across many housing programs (e.g. Section 8, 811 and 202) and many providers just call all of their housing Section 8 regardless of its unique nature.

B. ***HUD income and asset rules***

1. The Housing Opportunity Through Modernization Act of 2016 (HOTMA) made many significant changes to housing programs administered by HUD. Many of those changes are beyond the scope of these materials and many have involve streamlining administrative processes for public housing authorities. However, there are important changes to the asset and income counting rules about which anyone assisting others establish and maintain affordable housing must be aware.

i. Asset Limits: families with "net family assets" exceeding $100,000 are not eligible for Section 8 and related assistance.

ii. Income counting and trust administration: Trusts fall into 3 categories and are treated according to the following chart.[16]

Trust Type	**Is the trust considered a net family asset?**	**Is the actual interest earned by the trust considered family income?**	**Are distributions of trust principal considered family income?**	**Are distributions of interest earned on the trust principal considered family income?**
Revocable Grantor is not part of the assisted family or household (and the family or household is not otherwise in control of the trust)	No	No	No	Yes, unless the distributions are used to pay for the health and medical expenses for a minor
Revocable Grantor is part of the assisted family or household (or the trust is otherwise under the control of the family or household)	Yes	Yes	No	No
Irrevocable (Typically, Special Needs Trusts are irrevocable.)	No	No	No	Yes, unless the distributions are used to pay for the health and medical expenses for a minor

[16] U.S. Dept. of Housing and Urban Development, Notice H 2023–10 Notice PIH 2023–27 *Table F2: Annual Income/Net Family Assets Scenarios based on Trust Type*, September 29, 2023.

C. ***HUD rule advantages for the elderly and people with disabilities***

1. There are some advantages for the elderly and people with special needs in the HUD rules for income and asset counting. Among them are the following:
    i. Reductions in countable income by $525 for any elderly family or disabled family,[17] and this amount will be indexed to inflation annually.
    ii. Reductions in countable income for amounts in excess of 10% of annual income for unreimbursed medical expenses for an elderly or disabled family member. (HOTMA unfortunately increased this threshold from 3%)[18]
        a. Unreimbursed expenses may include those related to caregivers and equipment necessary for a person with a disability to maintain employment of a member of the family (including that person). They may also include equipment, property modifications, assistance animals and costs of attendant care that helps a person with disabilities perform day-to-day tasks independently (e.g. bathing, doing laundry, cooking, etc.).[19]
    iii. Income of a live in aid is excluded from income.[20]

D. ***Specific housing types***

1. HUD 811 Supportive Housing for People with Disabilities
    i. Section 811 is a housing program for low-income people with disabilities. It combines a production program, a rent subsidy program and a supportive services

[17] For appropriate definition of "Family", see 24 CFR § 5.403
[18] § 5.611(a)(3)
[19] Id. See also, H 2023–10 Notice PIH 2023–27 at C.3.c.
[20] § 5.609(b)(8)

plan. The rent subsidy is paid through a Project Rental Assistance Contract (PRAC) with the owner of the housing.

ii. Section 811 projects are developed and operated by nonprofit housing organizations. These projects will have supportive services coming "to the door" of the residents. There will often be other services available as well. This form of housing is typically used for people with mental illnesses or those with intellectual disabilities.

2. HUD Section 202 Housing for the Elderly

i. Section 202 provides affordable housing with supportive services for elderly individuals. The household must have at least one person who is at least 62 years old. Frequently, 202 housing is coupled with low-income housing tax credits. Also, it is not unusual for these to include independent and assisted living units (though neither of those housing types are 202 housing). When these are congregate housing coupled with Section 8 rent subsidy, it is possible that the project is managing internal waiting lists. This means that a voucher may be available with each vacancy that occurs. That is, more frequently than the extensive waiting lists that you find when you contact the local PHA directly.

E. ***HUD Mainstream and Non-Elderly persons with Disabilities (NED) Vouchers***

1. Mainstream/NED vouchers are those that have a special purpose apart from other HUD vouchers for a household with one or more non-elderly persons with disabilities. The person with a disability does not have to be the head of household. The Mainstream Voucher is a NED program that allows people with disabilities to bypass waiting lists – these vouchers are historically underutilized.

2. Thousands of Mainstream and NED vouchers have been issued to PHAs. However, many PHAs have difficulty "recycling" these vouchers to persons with disabilities and instead have allocated them to ordinary voucher programs. HUD has only recently allowed PHA's to establish separate Mainstream voucher waiting lists.[21] This should allow for more effective allocation of these vouchers. Yet it is possible that some PHAs still have Mainstream voucher allocations available.

[21] S U.S. Dept. of Housing and Urban Development, Notice PIH 2024-30, August 20, 2024.https://www.hud.gov/sites/dfiles/PIH/documents/PIH_2024-30.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SHO# 21-001
RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)

January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)[1] and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in an appendix.

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to over 76 million low-income Americans, including many individuals with complex, chronic, and costly care needs. Many Medicaid and CHIP beneficiaries may face challenges related to SDOH, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations, including individuals with disabilities, older adults, pregnant and postpartum women and infants, children and youth, individuals with mental and/or substance use disorders, individuals living with HIV/AIDS, individuals living in rural communities, individuals experiencing homelessness, individuals from racial or ethnic minority populations,

[1] The Centers for Disease Control and Prevention (CDC) refers to SDOH as "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." See https://www.cdc.gov/socialdeterminants/about.html for CDC information on SDOH, including research on the impact of SDOH on health outcomes and health care costs. Healthy People 2030, which is managed by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services (HHS), uses a place-based framework that highlights the importance of addressing SDOH. Healthy People 2030 was released in 2020 and sets data-driven national objectives to improve health and well-being over the next decade. Healthy People 2030 SDOH objectives can be found here.

and individuals with limited English proficiency. Examples of adverse health outcomes linked to social and economic factors include: asthma attributed to certain home environments; diabetes-related hospital admissions related to food insecurity; falls due to physical barriers, safety hazards, or absence of needed home modifications; frequent use of the emergency department due to homelessness; and a risk of stress-related illness resulting from unemployment, among many others.[2,3]

SDOH have been shown to impact health care utilization and cost, health disparities, and health outcomes.[4] Current research indicates that some social interventions targeted at Medicaid and CHIP beneficiaries can result in improved health outcomes and significant savings to the health care sector.[5] These investments can also prevent or delay beneficiaries needing nursing facility care by offering services to facilitate community integration and participation, and help keep children on normative developmental trajectories in education and social skills.

While many states, managed care plans, and providers have recognized the importance of addressing SDOH for Medicaid and CHIP beneficiaries, the growing shift towards alternative payment models and value-based care has accelerated the interest in addressing SDOH within Medicaid and CHIP in order to lower health care costs, improve health outcomes, and increase the cost-effectiveness of health care services and interventions. In addition to their key roles in providing access to health care for many Americans, state Medicaid and CHIP agencies are in a unique position to address SDOH for Medicaid and CHIP beneficiaries, due to the broad range of services and supports, including home and community-based services (HCBS), that can be covered within Medicaid and CHIP programs and the high number of Medicaid and CHIP beneficiaries who face challenges related to SDOH because of low income and other reasons.[6]

This document is intended to supersede a 2015 CMCS Informational Bulletin on Coverage of Housing-Related Activities and Services for Individuals with Disabilities. This letter does not describe new flexibilities or opportunities under Medicaid and CHIP to address SDOH, but rather describes how states may address SDOH under the flexibilities available under current law.

---

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M., Addressing Patient's Social Needs, An Emerging Business Case for Provider Investment, May 2014. The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf

[3] Pynoos, J., Steinman, B., et al, Assessing and Adapting the Home Environment to Reduce Falls and Meet the Changing Capacity of Older Adults. J Hous Elderly. 2012; 26(1-3): 137–155. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6294465/pdf/nihms-953861.pdf

[4] Chisolm, D.J., Brook, D.L., Applegate, M.S. *et al.* Social determinants of health priorities of state Medicaid programs. *BMC Health Serv Res* 19**,** 167 (2019).

[5] Lipson, D., Medicaid's Role in Improving the Social Determinants of Health: Opportunities for States, June 2017. National Academy of Social Insurance. Available at: https://www.nasi.org/research/2017/medicaid%E2%80%99s-role-improving-social-determinants-health

[6] Braveman, P., S. Egerter, and D. Williams (2011). "The Social Determinants of Health: Coming of Age." Annual Review of Public Health, 32:381-398. https://www.annualreviews.org/doi/10.1146/annurev-publhealth-031210-101218?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed

Overarching Principles

State Medicaid and CHIP programs can utilize a variety of delivery approaches, benefits, and reimbursement methodologies to improve beneficiary outcomes and lower health care costs by addressing SDOH. Through several different federal authorities, CMS provides states with flexibility to design an array of services to address SDOH that can be tailored, within the constraints of certain federal rules, to address state-specific policy goals and priorities, including the movement from volume-based payments to value-based care, and the specific needs of states' Medicaid and CHIP beneficiaries. There are, however, several overarching principles that states are required to adhere to within their Medicaid programs in the context of providing services to address SDOH:

1. As specified in sections 1915(c)(4)(B), 1915(i)(1)(D)(i), and 1915(k)(1)(A)(i) of the Social Security Act (the Act), and operationalized by state implementation of medical necessity criteria authorized under 42 CFR 440.230(d), services must be provided to Medicaid beneficiaries based on individual assessments of need, rather than take a one-size-fits-all approach;

2. As required by section 1902(a)(25) of the Act and 42 CFR Part 433 Subpart D, Medicaid is frequently, but not always, the payer of last resort.[7] This requirement ensures that Medicaid resources are not duplicating other available funding streams, including but not limited to certain other federal funding sources, and that Medicaid aligns with other programs and fills gaps where appropriate. Accordingly, states must assess all available public and private funding streams, including Medicaid, to cover assistance with unmet social needs such as housing, nutrition, employment, education, and transportation when developing a strategy for addressing beneficiaries' SDOH[8];

3. As required by section 1902(a)(30)(A) of the Act, Medicaid programs must ensure methods and procedures relating to the utilization of, and the payment for, care and

[7] There are a few exceptions to the general rule that Medicaid is the payer of last resort. These exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. For more information on these exceptions, see https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf.

[8] States are encouraged to review guidance and information from CMS, other federal agencies, and non-federal entities to learn more about other federal and non-federal funding sources that can address SDOH. For example, the Administration for Community Living's *Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilitie*s (https://acl.gov/sites/default/files/programs/2020-06/ACL_Strategic_Framework_for_Action_v1_%20June%202020_final_508_v2.pdf) provides information on how states can leverage federal and state funded programs to address SDOH through networks of community-based organizations. As another example, the Joint HHS, Housing and Urban Development (HUD), and United States Department of Agriculture (USDA) Informational Bulletin, *Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability* (https://www.medicaid.gov/federal-policy-guidance/downloads/cib081920.pdf) is intended to support state agencies with more effectively coordinating existing federal resources related to home accessibility across multiple sectors as part of their efforts to increase home safety and accessibility for older adults and people with disabilities living in rural communities.

services are consistent with efficiency, economy, and quality of care. This requirement ensures that Medicaid programs expend resources in a prudent manner. States should ensure that services provided to address SDOH are limited to those expected to meet the beneficiary's needs in the most economic and efficient manner possible and are of high quality; and

4. 42 CFR 440.230(b) requires that each Medicaid service be sufficient in amount, duration, and scope to reasonably achieve its purpose.

Certain federal Medicaid authorities also have specific evaluation, measurement, reporting, or other related requirements. These requirements are discussed below in the section on federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. Beyond these specific federal requirements, CMS strongly encourages states to build in continuous evaluations of any services, interventions, or initiatives intended to address SDOH and to make changes, as needed and allowable under federal requirements, to meet programmatic goals. In addition, when requesting federal approval to cover services that address SDOH, such as when requesting federal waiver or demonstration authority, states should be prepared to support the request with evidence and explain how they will monitor and evaluate the effectiveness of the services, consistent with the requirements of the federal authority that the state is requesting to use to cover the services. These requests will be substantially strengthened if states can demonstrate that the services, programs, and interventions that they are proposing to cover have been demonstrated to improve quality of care, improve outcomes, and/or lower costs for Medicaid and CHIP beneficiaries.

Services and Supports that Can Be Covered Under Medicaid to Address SDOH[9,10]

States have flexibility to design an array of services to address SDOH. However, the services and supports that states can cover tend to fall within several categories of services, including housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management. This section provides a high-level description of these service categories. Additional information on the extent to which the services and supports described in this section can be covered under different federal authorities is provided in the next section. When developing and implementing a strategy to address SDOH, the state Medicaid agency should

[9] Additional flexibilities are available to states during public health emergencies and in response to natural and manmade disasters. See https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html for guidance, resources, and other information available to states during the COVID-19 Public Health Emergency. See https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html and https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home for guidance, information, and other resources related to public health emergencies, natural disasters, and manmade disasters, generally.

[10] The information included in this section is not an exhaustive list of all services and supports that can be covered under Medicaid. There may be other opportunities for states to claim Medicaid reimbursement related to the delivery of benefits and services discussed in this letter, such as for the cost of interpreter and translation services that are provided to people with limited English proficiency. See https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html for more information.

work with other state agencies to leverage all federal funding the state receives to address SDOH.

Except where noted, the Medicaid coverage options and services and supports described below can be utilized for children and youth, non-elderly adults (including adults with disabilities), and older adults. However, some services and supports are typically targeted at only certain populations or age groups, although they could be covered by states more broadly. In particular, home-delivered meals and some housing and tenancy supports are not generally targeted at children, employment supports are most commonly offered to non-elderly adults with disabilities, and educational supports are typically only available to children with disabilities and young adults with disabilities.

Following this section is a description of applicable Medicaid coverage provisions that could be used by CMS to give a state authority to implement the services and supports described below. CMS notes that the following services and supports must be provided in accordance with the parameters of the individual benefit authorizing the activity. For example, any service and support authorized under HCBS waiver or state plan provisions at section 1915(c) or (i) of the Act, respectively, must be articulated in a state-approved person-centered service plan based on an individual assessment of need. CMS has also indicated in published guidance[11] that services must be for the benefit of the Medicaid-eligible individual only, and not for "general utility."[12] We further note the requirement at 42 CFR 441.301(c)(2)(xii) that the state-approved person-centered service plan prevents the provision of unnecessary or inappropriate services. Additional benefit parameters will be discussed throughout the remainder of this document, and should be taken into account when proposing Medicaid coverage of these services and supports.

A. Housing-Related Services and Supports

Federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions[13]).[14] However, federal financial participation is generally available under certain federal authorities for housing-related supports and services that promote health and community integration, including home accessibility modifications, one-time community transition costs, and housing and tenancy supports, including pre-tenancy services and tenancy sustaining services.

1. Home Accessibility Modifications

Home accessibility modifications are either temporary or permanent changes to a home's interior or exterior structure to improve individuals' ability to remain in their homes and

[11] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf; see page 41, question 4.
[12] Examples of items that are of "general utility" include phone cards and minutes and central air conditioning.
[13] Centers for Medicare & Medicaid Services. "Institutional Long Term Care." 2019. Available at https://www.medicaid.gov/medicaid/ltss/institutional/index.html. Accessed on August 21, 2020.
[14] This is codified in multiple regulatory provisions. See, for example, 42 CFR § 441.310(a)(2) and 42 CFR § 441.360(b).

communities.[15,16] Depending on the home's structural characteristics, temporary modifications could include the installation of a wheelchair ramp outside the home or grab bars in the shower. Permanent modifications could include enlarging a doorway to allow wheelchair passage. Homes that are more accessible and usable facilitate independent living, reduce the risk of social isolation, improve quality of life, and promote community integration.[17] CMS notes that these services and supports must be specific to the individual's needs based on his or her disabilities and/or health conditions and not of general utility in the home.

2. One-Time Community Transition Costs

Community transition costs can help to facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses.[18] One-time community transition costs may include payment of necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.

3. Housing and Tenancy Supports

Housing and tenancy supports include both pre-tenancy services, which assist individuals to prepare for and transition to housing, and tenancy sustaining supports, which are provided once an individual is housed to help the person achieve and maintain housing stability. Examples of pre-tenancy services include:

- conducting an individualized screening and community integration assessment that identifies the individual's preferences for, and barriers to, community residence – including factors such as accessibility and affordability;
- developing a community integration plan based on the community integration assessment;
- assisting with the housing search, including training on how to: search for available housing; identify the adequacy and availability of public transportation in areas under

[15] Depending on the type of home modification, three Medicaid coverage authorities could be relevant. Regulations at 42 CFR 440.70(b)(3)(ii) define medical equipment and appliances, as a component of the 1905(a) home health benefit, such that certain types of removable modifications could be encompassed when a beneficiary meets any state-defined medical necessity criteria. In the HCBS waiver program, section 1915(c)(4)(b) of the Act authorizes the Secretary to approve "other" services such as home modifications when there is a determination that but for these services the individual would require institutional placement, as documented in an approved plan of care. Home modifications could also be approved under the 1915(i) state plan option, for individuals who meet the state's established needs-based criteria, when based on an assessed need and documented in the individual's plan of care.
[16] Joint HHS, HUD, and USDA Informational Bulletin, Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability, issued August 19, 2020, https://www.medicaid.gov/federal-policy-guidance/downloads/cib081920.pdf.
[17] For more information on social isolation see: National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663.
[18] State Medicaid Director Letter SMD 02-008, Transition Costs Covered under Home and Community-Based Services Waivers, issued May 9, 2002, https://www.medicaid.gov/federal-policy-guidance/downloads/smd050902a.pdf.

consideration; complete the application for housing assistance and for the residence itself; and review and sign a lease or rental agreement, consistent with the community integration assessment and plan;
- ensuring that housing units are safe and ready for move-in;
- assisting in arranging for and supporting move-in, including moving expenses and transportation expenses related to the move when necessary and unavailable through other resources and identified in the person-centered service plan; and
- connecting the individual to community-based resources that provide assistance with activities such as securing required documents and fees needed to apply for housing and making any reasonable accommodation request(s) related to the individual's disability to a housing provider.

Examples of tenancy sustaining services include:

- providing early identification and intervention for behaviors that may jeopardize housing (e.g., lease violations);
- education or training on the role, rights, and responsibilities of the tenant and landlord;
- connecting the individual to community resources to maintain housing stability; and
- individualized case management and care coordination (e.g., connecting the individual with needed Medicaid and non-Medicaid service providers and resources) in accordance with the person-centered care plan and the individual housing support plan.

B. Non-Medical Transportation[19]

Individuals who need Medicaid-funded home and community-based services (HCBS) may lack transportation to access community activities and resources. States have the option to cover non-medical transportation to enable individuals receiving Medicaid-funded HCBS to gain access to such activities and resources when other options, such as transportation by family, neighbors, friends, or community agencies, are unavailable. Examples include transportation to grocery stores and places of employment.

C. Home-Delivered Meals

Older adults and individuals with disabilities who need Medicaid-funded HCBS may need additional assistance with meeting nutritional needs due to functional limitations or challenges that make it difficult to go shopping or prepare meals on their own. Home-delivered meals can

[19] In addition to the opportunities for states to provide non-medical transportation that are described in this letter, states generally are required to assure necessary transportation to and from covered medical care. This does not necessarily mean the state is responsible for providing a ride, but unless this requirement has been waived or identified as inapplicable, the state must assure that a beneficiary without another reasonably available and appropriate means of transportation receives necessary transportation to and from covered services. Federal Medicaid regulations require states to detail the methods that the state will use to meet this requirement in the states' approved state plan. Each state is responsible for determining how to structure and administer transportation under broad federal requirements.

help to supplement the nutritional needs of these individuals when there is an assessed need and the services are identified in the person-centered service plan.[20,21]

D. Educational Services

Under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child's individualized education plan (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP). These educational services can help children with disabilities achieve their educational goals. Medicaid reimbursement is available for covered services that are included in the child's IEP and IFSP provided to eligible beneficiaries by qualified Medicaid providers.[22] States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting if the children are determined to need those services, the services are furnished by qualified Medicaid providers, and the services meet all of the requirements set forth in the State Medicaid Director Letter 14-006.[23,24]

E. Employment

Employment can help to lift low-income individuals and families out of poverty and, in doing so, address a broad range of social needs that can impact health. As discussed in SMDL 18-002, CMS supports states' efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.[25] States can test incentives that provide a pathway to coverage for certain individuals who may not be eligible for Medicaid through the state plan to opt into Medicaid coverage, or for some beneficiaries to receive enhanced benefits, through participation in work or other community engagement activities through a demonstration projects authorized under section 1115 of the Act.

---

[20] As noted previously, federal financial participation is not available to state Medicaid programs for room and board (except in certain medical institutions). CMS defines the term "board" to mean three meals a day or any other full nutritional regimen; see section 4442.3 of the State Medicaid Manual at www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927.

[21] State NWD Systems employ person centered counselors that assist people in accessing home delivered meal programs and enrolling in Farmers Market voucher programs and other food and nutrition programs sponsored by the US Department of Agriculture and state Department of Agriculture programs.

[22] As noted earlier, there are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. As indicated by section 1903(c) of the Act, Parts B and C of the Individuals with Disabilities Education Act (IDEA) is one example of this exception to the payer of last resort rule.

[23] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care), issued December 15, 2014, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[24] Certain services authorized under sections 1915(c), (i), and (k) of the Act have restrictions on Medicaid coverage of educational services.

[25] State Medicaid Director Letter SMD 18-002, Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued January 11, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

These measures may also enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover, thereby maintaining the long-term fiscal sustainability of a state's Medicaid program and enabling states to provide medical services to more Medicaid beneficiaries.

In addition, for individuals with disabilities, who are less likely to be employed than individuals without disabilities,[26] Medicaid-funded HCBS can provide supported employment services for individuals who need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting. States may define other models of individualized supported employment that promote community inclusion and integrated employment. Supported employment can vary substantially depending on the individual's needs and might include customized employment, job coaching to provide supports and services not specifically related to job skill training that enable the individual to successfully integrate into the job setting (e.g., instruction on how to ameliorate the impacts of a mental illness on the job), and personal care services to provide assistance at an individual's place of employment.

Health care services and supports not generally available through programs other than Medicaid can constitute a barrier to employment. However, Medicaid "buy-in" programs, available in most states, and often described as "Working Disabled" programs, allow workers with disabilities access to Medicaid community-based services not available through other insurers, such as personal care attendant services, by paying into Medicaid on a sliding scale. These programs have higher (or no) asset limits to allow individuals with disabilities who need these services to retain them while working and earning salaries above the standard Medicaid limits.[27]

F. Community Integration and Social Supports

Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to choose to receive services in their home or community rather than institutions. These programs serve a variety of targeted populations groups, such as older adults, people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. Examples of HCBS that facilitate community integration include instruction on how to utilize public transportation, and companion services to accompany the individual into places in the community to provide assistance. HCBS in non-residential settings also afford individuals opportunities to participate in the community by providing and/or facilitating access to community-based activities with individuals not receiving Medicaid HCBS. For example, companion services can provide critical socialization supports to assist individuals as they integrate into their broader community and develop relationships.

[26] Bureau of Labor Statistics, U.S. Department of Labor. Persons with a Disability: Labor Force Characteristics — 2019. February 26, 2020). https://www.bls.gov/news.release/pdf/disabl.pdf

[27] Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (P.L. 106-170) includes the Medicaid Buy-In provision for working individuals with disabilities between the ages of 18 and 64. Forty-six states currently have Medicaid buy-in programs.

G. Case Management

Case management assists eligible individuals to gain access to needed medical, social, educational, and other services. Case management services are often a critical component of the services and supports described above, although case management can also be used to address a broader range of needs and to assist Medicaid and CHIP beneficiaries with accessing other Medicaid and non-Medicaid services.

Opportunities to Address SDOH under Medicaid and CHIP Authorities

Federal Medicaid law requires states to provide certain mandatory Medicaid state plan benefits under sections 1902(a)(10) and 1905(a) of the Act and 42 Code of Federal Regulations (CFR) §§ 440.210 and 440.220. Additionally, pursuant to section 1905(a)(4)(B) and (r)(5) of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide all medically necessary section 1905(a) services coverable under the Medicaid program to eligible children and youth under age 21 in order to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

In addition, states can choose to provide optional benefits under state plan authority, as well as through waiver authority under section 1915 of the Act, or they can offer non-mandatory benefits under demonstration project waiver or expenditure authorities under section 1115 of the Act. States have a certain degree of flexibility in determining which non-mandatory benefits to provide under these authorities. In most cases, state flexibility is limited by section 1902(a)(1) of the Act and 42 CFR § 431.50 (statewideness), section 1902(a)(17) of the Act and 42 CFR § 440.230 (requirements regarding the amount, duration, and scope of covered services), and section 1902(a)(10)(B) of the Act and 42 CFR § 440.240 (comparability of services within and among eligibility groups), among other provisions. These requirements apply unless the statute makes them inapplicable to the specific benefit or CMS waives or makes them inapplicable.

More information on some of these coverage authorities and how they can address SDOH, as well as other opportunities for states to address SDOH in their Medicaid and/or CHIP programs, is provided below. Except where noted or otherwise clarified, states can receive federal financial participation for the services, benefits, and other opportunities described in this section, assuming they meet the requirements of the coverage authority. It is important to note that many of the services outlined throughout this document may be provided using telehealth modalities in addition to in person visits. States are strongly encouraged to assess their telehealth frameworks to determine if there are unnecessary restrictions preventing maximum utilization of telehealth for the services appropriate to be delivered via telehealth.

Appendix A also provides a summary of key authorities, the characteristics of beneficiaries who are eligible to receive services under that authority, and the types of SDOH that each authority can be useful to address. Appendix B provides a summary of services and supports that can be covered under Medicaid and CHIP to address SDOH, including a description of the services and supports, examples, potential target populations, and federal authorities that can be used to cover the services and supports. States may have additional flexibility to cover additional services and supports under some of the authorities listed below, including section 1115 demonstrations,

managed care programs, CHIP Health Services Initiatives (HSIs), and the Money Follows the Person demonstration.

A. Section 1905(a) State Plan Authority

Section 1905(a) state plan services can assist Medicaid-eligible individuals to gain access to needed medical and social services. The following are examples of section 1905(a) state plan services that can address SDOH for Medicaid-eligible individuals.

1. Rehabilitative Services Benefit

Description: The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."

Who Is Eligible: Individuals who meet any state-defined medical necessity criteria for covered services.

How Rehabilitative Services Can Address SDOH: Rehabilitative services may include services to help eligible individuals regain skills and functioning necessary to address SDOH. For example, a Medicaid beneficiary may need help with restoring social interaction behaviors and problem solving. These skills are necessary when navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, negotiating with property owners or property managers, paying bills, and interacting with neighbors or co-workers. Practitioners who furnish rehabilitative services must meet a state's qualifications, including any licensure, certification, education, training, experience and supervisory arrangements the state requires.

Rehabilitative services may include services furnished by peers. For beneficiaries with serious mental illness (SMI) or substance use disorders (SUD) in particular, peer supports can be effective at helping individuals coordinate care and social supports and services. Peer supports can facilitate linkages to housing, transportation, employment, nutritional services, and other community-based supports. In addition to section 1905(a)(13) rehabilitative services, states may choose to deliver peer support services through section 1915(b) and 1915(c) HCBS waiver programs and under section 1115 authority.

For additional information, CMS published State Medicaid Director Letter (SMDL) #07-011[28] in 2007, providing policy guidance on supervision requirements, care coordination, and minimum training criteria for peer support providers.

State Example: New Jersey added peer support services to its rehabilitative services benefit (State Plan Amendment (SPA) 19-0015), which allows peer support specialists to provide

[28] Centers for Medicare & Medicaid Services. State Medicaid Director Letter SMD 07-011, issued August 15, 2007. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf

nonclinical assistance and support throughout all stages of the SUD or SMI recovery and rehabilitation process. Services include but are not limited to: participating in the treatment planning process; mentoring and assisting the beneficiary with problem solving, goal setting and skill building; initiating and reinforcing a beneficiary's interest in pursuing and maintaining treatment services; providing support and linkages to specialty support services; sharing experiential knowledge, hope, and skills; advocating for the beneficiary; and being a positive role model.

2. Rural Health Clinics/Federally Qualified Health Centers

Description: Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) services are defined in section 1905(a)(2)(B), 1905(a)(2)(C), and 1905(*l*)(1) and (2) of the Act, and include certain services listed in section 1861(aa) of the Act, as described in section 1905(*l*)(1) and (2). FQHC and RHC services are mandatory Medicaid state plan services for categorically needy populations. FQHCs and RHCs generally serve medically underserved populations and areas. Medicaid-covered services provided by FQHCs and RHCs include primary and preventive services provided by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers, as well as other ambulatory services included in the state plan.

Who Is Eligible: Individuals who meet any state-defined medical necessity criteria. FQHC and RHC services are mandatory for beneficiaries in the categorically needy eligibility groups.

How RHCs/FQHCs Can Address SDOH: RHCs/FQHCs' role as "safety net providers" presents a unique opportunity to adopt innovative strategies to improve care and reduce health costs for individuals with complex socioeconomic needs. For example, RHCs/FQHCs could be reimbursed under Medicaid to screen individuals to identify social needs, collect and analyze SDOH data to inform interventions, and co-locate social services, as long as these activities are delivered as part of a Medicaid-covered RHC/FQHC service (see the RHC/FQHC description above for more information).

State example: Under Washington State's approved section 1115 demonstration, entitled "Medicaid Transformation Project-Foundational Community Supports," the state partners with FQHCs that administer Health Care for the Homeless[29] programs to provide supportive housing and supported employment supports to eligible participants. These "Foundational Community Supports," or "FCS," are services that would otherwise be allowable under section 1915(c) or 1915(i) of the Act.

3. Case Management and Targeted Case Management Services

Description: Case management services, as defined under sections 1905(a)(19) and 1915(g) of

[29] The Public Health Service Act, section 330(h), 42 USC 254b(h), provides that the U.S. Department of Health and Human Services, Health Resources Services Administration may award grants "for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and youth, children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness." Section 330(h)(2) further provides that "in addition to required primary health services, an entity that receives a grant under this subsection is required to provide substance abuse services as a condition of such grant." For a list of the more than 200 Health Care for the Homeless grantees, see: https://nhchc.org/directory/.

the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. Under 42 CFR § 440.169(d), case management services must include all of the following: comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services; development and periodic revision of a specific care plan; referral to services and related activities to help the eligible individual obtain needed services; and monitoring and follow-up activities. Case management services can also include assisting individuals transitioning from a medical institution to the community.

Who Is Eligible: Case management services are an optional Medicaid benefit. If a state elects to cover case management under the Medicaid state plan, the state can also opt to provide this benefit without regard to the statewideness and comparability requirements at section 1902(a)(1) and (a)(10)(B) of the Act, in which case the benefit is referred to as targeted case management (TCM). As a result, states can target the benefit to specific populations, as described in section 1915(g)(1) of the Act, such as Medicaid-eligible individuals with SMI and/or SUD who are experiencing or at risk of experiencing homelessness, youth transitioning out of foster care, individuals transitioning from medical institutions, and older adults with chronic medical conditions. Additionally, states are not required to furnish TCM services statewide.

How Case Management and Targeted Case Management Services Can Address SDOH: Case management services offer several flexible ways to assist individuals with medically and socially complex needs. As part of identifying the total needs of an eligible individual with significant social needs, case management services must include activities to help link the individual to community-based medical, social, and educational services. A multi-disciplinary team approach may be employed to furnish case management services. For example, case managers can coordinate the team's resources and expertise to inform a comprehensive, medical, educational, and social assessment, as well as to create and implement a comprehensive plan of care. States may also reimburse for services based on case or task complexity to reflect the need to draw on additional resources to develop and implement comprehensive assessments, care plans, and follow through services.

State Example: Colorado added TCM services as a state plan benefit (SPA 18-0021) to provide case management to individuals who are transitioning from a nursing facility, intermediate care facility for individuals with intellectual and developmental disabilities (ICFs/IID), or Regional Centers, which serve people with intellectual and developmental disabilities who have intensive needs or who have recently transitioned to a community setting. The TCM services support individuals to successfully integrate into community living by facilitating linkages to needed assistance.

B. Home and Community-based Service (HCBS) Options

Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions. These programs serve a variety of targeted populations groups, such as older adults, people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses, and can be particularly effective in addressing SDOH for Medicaid beneficiaries. For example, HCBS programs can play an important role in

coordinating medical and non-medical services and supporting an individual with achieving community living goals.

Medicaid's HCBS authorities require the development of a person-centered service plan, outlining an individual's goals and preferences, and their service and support needs to pursue them. Services and supports that may address SDOH are authorized based on an assessment of need and are identified in that person-centered service plan. The person-centered planning process reflects any needed services, including non-Medicaid community resources.

States have options to determine the ways in which these optional HCBS are provided, and the role Medicaid beneficiaries play in the provision of those services. HCBS can be provided under agency-delivered models, in which the provider agency uses employed or contracted staff to furnish services. HCBS can also be provided under self-directed models. Self-direction allows individuals to have the authority to employ staff of their choosing and/or control a defined budget that can be used to purchase goods and services and hire direct service workers and other providers necessary to remain in community-based settings based on the goals in the person-centered plan.

As indicated earlier, HCBS authorities such as the section 1915(c) waiver and section 1915(i) state plan option include defined benefit parameters that must be met. Additional information is described in the following sections.

1. Section 1915(c) HCBS Waiver Program

Description: Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. However, those waiver services must not cost more than what would have been incurred to care for waiver participants in an institution.

Who Is Eligible: States can enroll individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICFs/IID), and the need for services must be based on an assessed need and identified in a state-approved service plan. Section 1915(c) allows states to waive certain Medicaid requirements (i.e., statewideness, comparability, income and resource rules applicable in the community), and, thus, allows states to furnish services to target populations by age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with mental illnesses, and older adults, among others.

How Section 1915(c) Waiver Programs Can Address SDOH: Under section 1915(c) waiver programs, states can cover a range of services that address SDOH while supporting individuals to achieve community integration goals and to maximize independence and safety in the home. Examples of services that states can cover within section 1915(c) waiver programs to address SDOH include:

- Service coordination or case management in order to facilitate access to supports and services to address SDOH, including during transitions from hospital to home;
- Home accessibility adaptations to the private residence of the beneficiary or his or her family that are required by the beneficiary's service plan and necessary either to ensure the beneficiary's health, welfare, and safety or to enable functioning with greater independence in the home[30];
- One-time community transition costs, which are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a living arrangement in a private residence where the person is directly responsible for his/her own living expenses[31];
- Housing and tenancy supports to:
    - assess the individual's community integration needs and present options;
    - assist in finding and securing housing, including assistance in the completion of housing applications and in securing required documentation (e.g., Social Security card, birth certificate, prior rental history);
    - assist the individual in communicating with the property owner and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the property owner and/or property manager; and
    - help the individual to remain in their community housing, such as through assistance with housing recertification, and assistance with dispute resolution with property owners and neighbors;
- Habilitation services,[32] which can include a wide variety of activities related to social supports and needs that impact health, such as interpersonal skills training to help an individual acquire and maintain employment or to successfully engage with the community-based housing system, particularly when interacting with neighbors, negotiating with landlords, and managing a household budget. This may also include assistive technology that enable a person to acquire and/or maintain employment;
- Non-medical transportation to support the individual with gaining access to home and community-based services, activities, and resources such as unpaid community supports

[30] Such adaptations could include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that accommodate the medical equipment and supplies that are necessary for the welfare of the beneficiary. However, they may not include those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

[31] One-time community transition costs may only be covered more than once in an individual's lifetime if s/he returns to an institutional and/or congregate setting and, as a result, loses the more integrated residence. Allowable expenses are those necessary to enable the person to establish a basic household that do not constitute room and board and may include: security deposits required to obtain a lease; essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens; moving expenses; set-up fees or deposits for utilities; services necessary for the individual's health and safety such as pest eradication; necessary home accessibility adaptations; and activities to assess need, arrange for, and procure needed resources. Please note that one-time transition costs under section 1915(i) state plan benefits are the same as under section 1915(c) waivers.

[32] Defined at section 1915(c)(5) of the Act, "habilitation services means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."

which will assist the individual in establishing a presence in his/her community, consistent with and documented in his or her service plan[33];

- Home-delivered meals, including in home and community-based settings other than private residences (e.g., assisted living facilities), as long as the meals do not constitute a full nutritional regimen and the individuals receiving the service have an assessed need for home-delivered meals documented in their person-centered service plan;
- Supported employment services,[34] which are ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting.[35]
- Assistive technologies to facilitate communication between the individual, the individual's support network, and the larger community.

Under section 1915(c)(4)(B), states can also propose "other" types of services that may assist in diverting individuals from institutional placement and supporting community living for eligible individuals. These services can include a broad array of supports and activities designed to address social and economic factors that affect health. However, it is critical to note that Medicaid coverage does not extend to supporting room and board costs or other benefits that are not directly related to the provision of HCBS. CMS also notes that these services and supports must be specific to the individual's needs based on his or her disabilities and/or health conditions and not of general utility.

State Example: Maryland's section 1915(c) Community Supports Waiver targets individuals with developmental disabilities of all ages who have an Intermediate Care Facility for Intellectual Disabilities (ICF/IID) Level of Care (LOC). It is designed to provide support services to participants and their families, to enable participants to work toward self-determination, independence, productivity, integration, and inclusion in all facets of community life across their lifespans. The section 1915(c) Community Supports Waiver is the foundation for the Increased Community Services (ICS) program, which is authorized through the Maryland HealthChoice section 1115 demonstration. The ICS program mirrors the Community Supports Waiver in all aspects except eligibility. The Community Supports Waiver service package includes support to individuals with varying medical needs, support to individuals transitioning from institutional settings and significant employment support to uphold the state's Employment First, Meaningful Day program outlook. Services can support integrated life domains that are important to a good quality of life, including daily life, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. This waiver allows services to be delivered through both traditional and self-directed service delivery models.

---

[33] Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge should also be utilized.

[34] See https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-09-16-2011.pdf for more information.

[35] Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. States may define other models of individualized supported employment that promote community inclusion and integrated employment. Job coaching can also provide supports and services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. For example, a job coach may provide instruction on how to ameliorate the impacts of a mental illness on the job. Additionally, personal care attendants may provide hands-on assistance at an individual's place of employment.

2. Section 1915(i) State Plan Benefit

Description: Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M.

Who Is Eligible: Under section 1915(i), eligible individuals are those who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community. Section 1915(i) also offers states the option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group (e.g., pregnant women, individuals receiving Supplemental Security Income, children in foster care). The lower threshold of needs-based criteria must be "less stringent" than institutional and section 1915(c) HCBS waiver program level of care. Needs-based criteria are factors used to determine an individual's requirements for support that can only be ascertained for a given person through an individualized evaluation of need and may include but cannot only include state-defined risk factors, such as risk of or experiencing homelessness, risk of food insecurity for individuals with diabetes, or risk of social isolation for older adults with chronic conditions. Section 1915(i) services must be offered statewide.

How Section 1915(i) State Plan Services Can Address SDOH: States have the option to cover any services permissible under section 1915(c) HCBS waivers, which include services necessary to live in the community (see Section 1915(c) HCBS Waiver Programs above for more information**)**.[36]

State Example: Minnesota's section 1915(i) State Plan Amendment (SPA 18-0008) covers housing stabilization services for individuals with disabilities who are experiencing or at risk of experiencing homelessness and individuals with a disability with mental illness or substance use disorders who are living in institutions or other segregated settings or are at risk of living in those settings. Under Minnesota's section 1915(i) SPA, housing stabilization services include supports that help people plan for, find, and move to homes of their own and supports that help a person to maintain living in their own home. Minnesota's needs-based criteria targets individuals who are assessed to require assistance with at least one need in the following areas resulting from the presence of a disability and/or a long-term or indefinite condition: communication, mobility; decision-making; and/or managing challenging behaviors and is experiencing (risk factor) housing instability.

3. Section 1915(j) Optional Self-Directed Personal Assistance Services

Description: Section 1915(j) self-directed personal assistance services (PAS) means personal care and related services, or HCBS otherwise available under the state plan or a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the PAS option.

[36] The one-time transition costs under section 1915(i) state plan benefits are the same as under section 1915(c) waivers.

Who Is Eligible: Individuals must be eligible for state plan personal care services or a section 1915(c) waiver program

How Section 1915(j) Optional Self-Directed Personal Assistance Services Can Address SDOH: Self-directed PAS also includes, at the state's option, items that increase the individual's independence or substitute for human assistance (such as a microwave oven, grab bars, or an accessibility ramp) to the extent that expenditures would otherwise be made for the human assistance. Individuals' budgets may be used to purchase goods and services, supports, or supplies related to a need or goal identified in the individuals' state-approved person-centered service plans. Services authorized under the section 1915(j) state plan option facilitate beneficiary autonomy and assist individuals in participating in their communities, thereby reducing the likelihood that individuals will experience challenges related to SDOH.

4. Section 1915(k) Community First Choice Optional State Plan Benefit

Description: The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC state plan expenditures.

Who Is Eligible: Individuals who meet the state's institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID)

How Section 1915(k) Community First Choice Can Address SDOH: There are required services that must be included in all CFC programs, as well as additional services that may be included at the state's option.[37] States electing CFC are required to cover the following services, subject to the conditions described above: (1) services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks, through hands-on assistance, supervision, and/or cueing; (2) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks; (3) back-up systems or mechanisms to ensure continuity of services and supports; and (4) voluntary training on how to select, manage, and dismiss attendants. Section 1915(k) services must be offered state-wide.

Optional services states may cover in their CFC benefit include: (1) expenditures for transition costs (such as first month's rent and utilities, bedding, and basic kitchen supplies) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and (2) expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance.

As with section 1915(j), services authorized under the section 1915(k) state plan option facilitate beneficiary autonomy and assist individuals in participating in their communities, thereby reducing the likelihood that individuals will experience challenges related to SDOH.

[37] For more information on section 1915(k), see https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html.

State Example: Connecticut's section 1915(k) Community First Choice SPA provides non-recurring transitional services to enable a qualified individual transitioning from a nursing facility, institution for mental diseases, or ICF/IID to a home and community-based setting to establish a basic household. Services may include: essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; transportation expenses to pay for trips associated with locating housing; set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water; and services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

C. Section 1115 Demonstrations

Description: States can utilize section 1115 demonstration authority to test new strategies to promote the objectives of the Medicaid and CHIP programs, including certain strategies that are not available under other authorities. Under section 1115 authority, the Secretary may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act, including Medicaid and CHIP. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.[38] Pursuant to section 2107(e)(2) of the Act, section 1115 applies similarly to CHIP. Depending on the circumstances, states may seek section 1115 demonstration authority and also seek other authorities, as needed, or apply for a section 1115 demonstration without requesting flexibilities under other authorities.

Currently, CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. A budget neutral demonstration project does not result in Medicaid or CHIP costs to the federal government that are greater than what the federal government's Medicaid or CHIP costs would likely have been absent the demonstration. Under a section 1115 demonstration, similar to any other claim for Medicaid and CHIP federal financial participation, states are required to provide the necessary state share, consistent with federal regulations and statute, in order to draw down federal financial participation in authorized spending. CMS currently approves section 1115(a)(2) expenditure authority for services or populations that could not be covered under other authorities, i.e., costs not otherwise matchable, only if the state identifies offsetting savings to ensure the demonstration remains budget neutral. In cases where expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid or CHIP state plan or other title XIX authority, such as a waiver under section 1915 of the Act, CMS considers these expenditures to be "hypothetical" expenditures that do not necessitate savings to offset the otherwise allowable coverage.[39] Section 1115

[38] 42 U.S.C. § 1315.
[39] Centers for Medicare & Medicaid Services. SMDL #18-009. August 22, 2018. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.

demonstrations are usually approved for an initial 5-year period, with a possible 3-year or 5-year renewal period after the first 5 years. Subject to the public notice and transparency requirements, CMS may approve an extension for a period up to 10 years of routine, non-complex section 1115 demonstration and expenditure authorities that have been proven successful based on monitoring and evaluation data.[40]

Just as is the case for all section 1115 demonstrations, states that receive CMS approval for section 1115 demonstration authority to address SDOH are expected to conduct independent and robust evaluations of the demonstration. These evaluations generally draw on data collected for monitoring, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes. An interim evaluation is generally completed one year before the expiration of the demonstration, and under 42 CFR 431.424(d) must be included as part of the state's proposal to extend the demonstration. A summative evaluation is generally due 18 months after the demonstration period ends. States are also expected to submit an evaluation design, for CMS approval. CMS typically includes in special terms and conditions (STCs) for approved demonstrations a requirement that the state submit a monitoring protocol for CMS review and approval that describes the state's plan to monitor the demonstration in accordance with CMS expectations.

Who Is Eligible: States have significant flexibility in how they define target populations for demonstration services/activities, and states can determine their own state's needs. For instance, states can target populations by age and/or defined risk factors for services. States can target section 1115 demonstration services to particular geographic areas and/or populations meeting defined characteristics. However, CMS currently will not approve a demonstration providing coverage of services consistent with those authorized under section 1915(c), (i), or (k) benefits unless the state agrees to adhere to programmatic requirements of individual assessments of need with respect to those services.

How Section 1115 Demonstrations Can Address SDOH: Through section 1115 authority, states have the opportunity to test innovative approaches for addressing SDOH, subject to CMS approval, in ways that consider local challenges and response capabilities. States could, for instance, elect to pilot services that address SDOH for a specific target population or in a limited geographic area. Furthermore, states could choose to test services and supports that could address SDOH through expenditure authority. For example, states could test the effectiveness of providing: one-time community transition services for individuals experiencing or at risk of experiencing homelessness transitioning into supportive housing to increase housing stability, lower health care costs, and improve health outcomes for individuals who are experiencing homelessness or are at high risk for homelessness; or recurring chore or cleaning services to reduce asthma triggers in the home for individuals with poor asthma control. States can also test alternative payment methodologies that are designed to address SDOH. When assessing whether to approve a section 1115 demonstration, CMS would examine whether the demonstration is likely to assist in promoting the objectives of Medicaid or CHIP. In that assessment, CMS will

[40] Centers for Medicare & Medicaid Services. "Section 1115 Demonstration Process Improvements." CMCS Informational Bulletin. November 6, 2017. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf.

consider whether the demonstration is likely to furnish medical assistance in a manner that improves the sustainability of the safety net, such as if provisions influence health outcomes, improving beneficiaries' physical and mental health, which may in turn cause them to consume fewer health care resources while they are enrolled in Medicaid. This may potentially reduce the need for future Medicaid enrollment or result in lower costs for states over the long-term, thereby sustaining the state's Medicaid program.

Evaluation designs for section 1115 demonstrations to address SDOH should consider the extent to which the provision of services addressing SDOH results in improved integration of all services, increased care coordination effectiveness, improved health outcomes, and reductions in unnecessary or inefficient use of health care. States will be expected to comply with CMS requirements for monitoring and evaluation, as applicable, and as specified in the state's STCs.

State Examples: Washington State's approved section 1115 demonstration, entitled "Medicaid Transformation Project," authorizes the provision of Foundational Community Supports, which include both housing-related and supported-employment services. The intended goals of the demonstration are to integrate behavioral health into the larger health care system and to address housing and employment needs as SDOH. The aim is to improve health outcomes and reduce unnecessary utilization of high-cost health care services such as emergency department visits and inpatient bed stays. In addition, the state has developed and implemented training for LTSS social workers/case managers through their Tailored Supports for Older Adults (TSOA) and Medicaid Alternative Care (MAC) initiative. The state developed training materials to train Senior Information and Assistance/Aging and Disability Resource Center, state, and Area Agency on Aging staff on the new benefit levels, eligibility, authorization and qualification of providers.

North Carolina's approved section 1115 demonstration entitled "North Carolina Medicaid Reform Demonstration" authorizes the provision of the Enhanced Case Management and Other Support Services Pilot Program, to improve health outcomes and lower healthcare costs. The state is piloting evidence-based interventions, such as those for housing, transportation, and food. Beneficiaries eligible for enhanced case management are high-need adults age 21 and over, pregnant women, and children who must meet at least one state-defined needs-based criteria and at least one risk factor. Under the pilot program, North Carolina is developing an incentive payment fund to incorporate value-based payments to incentivize the delivery of high-quality care by increasingly linking payments for pilot program services to health and socioeconomic outcomes based on the pilot services provided during the demonstration and gathering the required data and experience needed for more complex risk-based models.

D. Section 1945 Health Homes

Description: The optional health home state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary services, acute care services, behavioral health (including mental health and substance use) services, and LTSS for individuals with chronic conditions, and thus help to ensure treatment of the "whole person." Section 1945 defines health home services as: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community

and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.[41] CMS expects that health outcomes for Medicaid beneficiaries enrolled in health homes will improve and that health homes will result in lower rates of emergency department use, reduction in hospital admissions and readmissions, reduction in health care costs and reliance on long-term care facilities, and improved experience of care for Medicaid beneficiaries with chronic conditions.

States implementing the section 1945 health home benefit receive enhanced federal matching funds for new health home programs or by adding health home services for new chronic conditions or expanding health home services to new geographic areas for an initial period (90 percent federal match for health home services during the first 8 fiscal quarters that the approved health home SPA is in effect). States can request an additional two quarters of enhanced federal match under SUD-focused health home SPAs approved on or after October 1, 2018. After the period of enhanced federal match ends, services are matched at the state's usual service rate.

Who Is Eligible: Section 1945 of the Act specifies that the health home state plan optional benefit is for "eligible individuals with chronic conditions," and gives states authority to target eligibility for services based on the chronic conditions a beneficiary has, notwithstanding the statewideness and comparability requirements in section 1902(a)(1) and (a)(10)(B) of the Act. CMS has explained in guidance that states can specify which chronic conditions their health homes will target, but are not permitted to limit the benefit to specific age groups. While all individuals served must meet the minimum statutory criteria, states may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions. The population must include all categorically needy individuals who meet the state's criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver), and at state option may include individuals in any medically needy group or section 1115 demonstration population.[42,43]

To qualify for health home services, Medicaid beneficiaries must: (1) have two or more chronic conditions; (2) have at least one chronic condition and be at risk of developing another; or (3) have at least one serious and persistent mental health condition. Chronic conditions are specified in the statute to include, but not be limited to: mental health conditions, SUD, asthma, diabetes, heart disease, and being overweight (i.e., Body Mass Index over 25). States may propose to target one or more conditions from the list, or, with approval from CMS, may target other conditions, such as HIV/AIDS.

How Section 1945 Health Homes Can Address SDOH: Among other things, health homes are responsible for connecting beneficiaries to other social services and supports. Under the section 1945 health home option, states can provide comprehensive care management services that could include an assessment to identify the need for assistance with SDOH, such as housing, transportation, employment, or nutritional services, the results of which could then help the health home to refer an individual to community and social support services. Health home

[41] For a definition of health home services, see https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf.
[42] https://www.medicaid.gov/sites/default/files/2020-02/health-homes-faq-12-18-17.pdf
[43] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD10024.pdf

services must also include comprehensive transitional care, including appropriate follow-up, from inpatient to other settings, and can support individuals as they transition between settings.

State Example: Maine's section 1945 health home SPA assesses housing needs and provides assistance with coordination of resources that help participants in accessing and maintaining safe and affordable housing. California implemented a section 1945 health home SPA for individuals with chronic physical conditions and SUD, including individuals experiencing or at risk of experiencing homelessness. California utilizes a housing navigator that develops relationships with housing agencies and permanent housing providers, including supportive housing providers, in order to refer and link Medicaid-eligible participants with community-based housing resources.

E. Managed Care Programs

Description: States may use a number of existing federal state plan and waiver authorities, including sections 1115(a), 1932, and 1915(b) of the Act, to authorize a risk-based managed care delivery system. These managed care authorities can be used by states to implement a managed care delivery system for state plan and waiver benefits. Under risk-based managed care arrangements, states provide some or all Medicaid covered benefits through a managed care organization, pre-paid inpatient health plan, or pre-paid ambulatory health plan, hereinafter referred to as a managed care plan. Managed care plans enter into contracted arrangements with state Medicaid agencies to provide all the services covered under the risk contract for a set amount, called a capitation payment (typically, per member per month, or PMPM), regardless of whether the enrollee uses services.

Who Is Eligible: Individuals who receive services under Medicaid managed care contracts who meet any state-defined medical necessity criteria for the services covered under the contract.

How Managed Care Can Address SDOH: There are a variety of mechanisms described in the Medicaid managed care statutes and regulations at 42 CFR part 438 that states may use to address SDOH. These include:

- *Section 1915(b)(3) Services:* Section 1915(b)(3) of the statute allows a state to share the savings resulting from the use of more cost-effective care with Medicaid beneficiaries in the form of additional health-related services. These savings must be expended for the benefit of Medicaid beneficiaries enrolled in the section 1915(b)(3) waiver and may be used to provide services for enrollees to address a wide range of SDOH. For example, states could obtain approval to add housing-related services under section 1915(b)(3) authority and have managed care plans provide those services for enrollees to identify, transition to, and sustain their housing. States could also add home-delivered meals as a service under section 1915(b)(3) authority and have managed care plans provide this service to individuals with chronic conditions, as long as the meals do not constitute a full dietary regimen and the individuals receiving the service have an assessed need for home-delivered meals documented in their person-centered service plan. As another example, states could add various environmental modifications as a service under section 1915(b)(3) authority and have managed care plans provide these services, such as humidifiers for individuals with asthma or other complicated respiratory conditions.

- *State Directed Payments (42 CFR § 438.6(c)):* Federal Medicaid managed care regulations include requirements for how states may direct plans to implement specific delivery system and provider payment initiatives under Medicaid managed care. These types of payment arrangements permit states to direct specific payments ("state directed payments") made by managed care plans to providers under certain circumstances[44] and can assist states in furthering the goals and priorities of their Medicaid programs, including to reinforce a state's commitment to addressing SDOH. For example, a state may require managed care plans to implement alternative payment models or incentive payments that incentivize providers to screen for socioeconomic risk factors, provided all regulatory requirements are met.

- *Managed Care Plan Incentive Payments (42 CFR §§ 438.6(b)(2), 438.5(e)-(f), and 438.7(b)(3)-(4)):* States may use incentive payments to reward managed care plans that make investments and/or improvements in SDOH in line with performance targets specified in the managed care plan contract, including implementation of a mandatory performance improvement project under 42 CFR § 438.330(d) that focuses on factors associated with SDOH. These incentive payments represent additional funds over and above the capitation rates. It is important to note that managed care plan contract payments that incorporate incentive payments may not exceed 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement.

  In the 2016 managed care rule (81 FR 27530), CMS specified that incentive payments made to the managed care plan in accordance with § 438.6(b)(2) should not be included in the denominator of the medical loss ratio (MLR) as such payments are in addition to the capitation payments received under the contract. However, these MLR standards can support states and managed care plans in their efforts to design and implement comprehensive strategies to address SDOH by ensuring amounts can be appropriately identified and classified within each managed care plan's MLR.

  Under §§ 438.5(e) and 438.7(b)(3), related to non-benefit costs, and §§ 438.5(f) and 438.7(b)(4), related to adjustments, states can develop specific assumptions and methodologies in capitation rate development related to profit margins and efficiency adjustments that are based on generally accepted actuarial principles and practices. An important principle of actuarial soundness is to ensure that rates paid to plans are appropriate, reasonable, and attainable. States may consider strategies to incentivize plan performance, such as by providing incentive payments to plans that achieve certain results, including lower costs and improved health outcomes. Such strategies could provide plans with an incentive to achieve improvement as a result of investments in SDOH. States could also consider other policy pathways for encouraging plans to invest in SDOH efforts. For example, some states

[44] State directed payments must meet the requirements under 42 CFR 438.6(c), including obtaining prior approval. Approval under 42 CFR § 438.6(c) provides authority for states to include contract requirements directing a plan's expenditures. Among other requirements, the payments must tie to the delivery of services that occurs during the rating period (e.g. not historical utilization). Approval under § 438.6(c) does not grant authority to cover services; states must already have Medicaid authority for the underlying services either under the Medicaid state plan or through a Medicaid waiver or demonstration program. Additional guidance and the preprint form states must use to obtain prior approval are available on Medicaid.gov: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html.

have established caps on plans' profit margins and required that profits beyond the cap be reinvested in SDOH efforts.

- *Coverage of Waiver and Nontraditional Services.* Under 42 CFR § 438.3(c), the final capitation rate for each managed care plan must be based only upon services covered under the state plan and represent a payment amount that is adequate to allow the managed care plan to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. In the 2016 final rule (81 FR 27537), CMS clarified that services approved *under* a waiver (e.g., sections 1915(b)(3), 1915(c), or 1115 of the Act) are considered state plan services and are encompassed in the reference to state plan services in 42 CFR § 438.3(c). Therefore, if services to address SDOH (e.g., peer support services, home-delivered meals) are approved under these waiver authorities for the state Medicaid program, and the services are included in the managed care contract; then the covered services must necessarily be incorporated in the final capitation rates as well as the numerator of a plan's MLR.[45]

- *Managed Care Plan Contracting Strategies (42 CFR § 438.208(b)).* States may develop and implement specific managed care plan procurement and contracting strategies to incentivize care coordination across medical and nonmedical contexts, including to address SDOH. For example, states may require managed care plans, through their plan contracts, to assess enrollee needs related to SDOH using a standardized assessment instrument,[46] refer enrollees to community-based supports and services as needed based on assessment results, track referrals to social services, include social or community health workers (CHWs) in care coordination teams, and other care coordination initiatives that promote holistic, person-centered care across medical and nonmedical contexts. CHWs are typically trained practitioners who provide certain follow-up medical and remedial care, as well as screening and preventive services. They can be a valuable link between enrollees and needed health care services. States may also require managed care plans to contract with community-based organizations with expertise in addressing SDOH for coordination of care purposes. Additionally, if managed care plans implement SDOH activities that meet the requirements in 45 CFR § 158.150(b) and are not excluded under 45 CFR § 158.150(c), managed care plans may include the costs associated with these activities in the numerator of the MLR as activities that improve health care quality under 42 CFR § 438.8(e)(3). States also may, as part of its procurement or pre-procurement strategies, encourage potential managed care plans to share promising practices and initiatives for addressing SDOH to encourage broader plan adoption of such practices and initiatives.

  Other examples of how states can leverage managed care to address SDOH include enrolling[47] beneficiaries into a managed care plan with expertise and capacity to manage the

[45] Under 42 CFR § 438.8(e), the numerator of a managed care plan's MLR for an MLR reporting year is the sum of the managed care plan's incurred claims, the managed care plan's expenditures for activities that improve health care quality, and fraud prevention activities.
[46] See, for example, the Accountable Health Communities Health-Related Social Needs Screening Tool (https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf).
[47] States must have an enrollment system for its managed care programs that complies with the requirements of 42 CFR 438.54. States can use a passive enrollment process and/or a default enrollment process that would include

care of enrollees with complex SDOH needs (such as people who have a history of chronic homelessness), requiring managed care plans to focus on addressing SDOH in performance improvement plans, or requiring managed care plans to report on quality measures related to SDOH.

- *Quality Measurement and Improvement.*[48] States can leverage managed care quality requirements in 42 CFR §§ 438.310 through 438.370, including Quality Strategies, quality assessment and performance improvement (QAPI) requirements, and external quality review to address SDOH within their managed care programs. States are required to develop, and update at least every three years, a managed care Quality Strategy. The Quality Strategy is the state's public-facing vision statement and roadmap for improving quality and access to care within its managed care program. States are required to ensure through their managed care contracts that Medicaid and CHIP managed care organizations, prepaid health plans, and certain primary care case management entities implement quality assessment and performance improvement (QAPI) programs in order to carry out the types of performance measurement and performance improvement projects (PIPs) that are necessary to realize the goals and objectives articulated in the Quality Strategy. States are also required to conduct an External Quality Review (EQR) to validate managed care organization (MCO) performance measures and PIPs and include these findings in an annual EQR technical report, which states post on their websites annually.

- States can require MCOs to focus on SDOH in their QAPI programs and/or PIPs. MCO performance in these QAPI programs and/or PIPs could also be integrated into the payment methodologies for certain managed care payments, such as managed care plan incentive payments. In addition, states can contract with external quality review organizations (EQROs) to conduct optional EQR-related activities, such as calculation of additional performance measures focused on SDOH or to conduct studies to gain a fuller understanding of how SDOH affect health outcomes among their beneficiaries. The Medicaid and CHIP Adult and Child Core Set measures are useful quality measures to demonstrate whether addressing SDOH has improved the health and health care of beneficiaries.[49]

Managed care plans may also voluntarily choose to cover "in lieu of services" to address SDOH for their members:

- *In Lieu of Services.* Managed care plans may cover, for enrollees, services or settings that are in lieu of services or settings covered under the state plan in accordance with 42 CFR § 438.3(e)(2), which requires:

---

criteria around the plan's expertise and capacity to manage the care of enrollees with complex SDOH needs so long as the other criteria outlined in 42 CFR 438.54 were also met.

[48] The managed care quality strategy, QAPI, and EQR requirements are addressed in 42 CFR §§ 438.310 through 438.370. While these quality requirements are specific to managed care, states are encouraged to leverage similar activities within their Medicaid fee-for-service programs to ensure that all Medicaid beneficiaries receive quality services and have positive health outcomes, regardless of delivery system.

[49] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

- The state determines that the in lieu of alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan;
- The enrollee is not required to use the alternative service or setting;
- The approved in lieu of service is authorized and identified in the managed care plan contract and offered to enrollees at the option of the managed care plan; and
- The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered state plan services, unless a statute or regulation explicitly requires otherwise.

Under the 2016 final rule (81 FR 27526), CMS also clarified that all services under § 438.3(e), including approved in lieu of services – such as in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit – can be considered as incurred claims in the numerator for purposes of the MLR.[50]

- *Value-Added Services.* Under 42 CFR § 438.3(e), a managed care plan may voluntarily cover, for enrollees, services that are in addition to those covered under the state plan, although the cost of these services is not and may not be included in the capitation rate; these services are often referred to as value-added services. Such value-added services, such as installation of a shower grab bar or healthy play and exercise programs, are plan services that may not be included in the capitation rate. Under the 2016 final rule (81 FR 27526), value-added services can be considered as incurred claims in the numerator for the purposes of the MLR calculation if the services are activities that improve health care quality under 45 CFR § 158.150 and are not excluded under 45 CFR § 158.150(c).

Under value-added and in lieu of services, there are opportunities for states and managed care plans to provide coverage for services that support SDOH, as long as federal Medicaid managed care regulatory requirements are met. For example, a managed care plan may voluntarily provide, as a value-added service, supportive housing services for a beneficiary living with severe mental illness who would otherwise cycle between hospital stays and homelessness, although the cost of these services may not be included in the capitation rate.

State Examples: Under the District of Columbia's Managed Care Organization federal fiscal year 2020 Contract, the QAPI language specifically addresses SDOH. The QAPI requires MCOs to analyze SDOH data to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees. MCOs identify and measure disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language), identify SDOH needs, and identify the causes for health disparities. MCOs then develop a plan of action and a timeline to remediate the SDOH and health disparities identified through targeted interventions.

To focus Medicaid managed care plans on improving asthma care, Maryland established a statewide PIP using the Asthma Medication Ratio measure. Each Medicaid managed care plan in

[50] Under 42 CFR § 438.8(e), the numerator of a managed care plan's MLR for an MLR reporting year is the sum of the managed care plan's incurred claims, the managed care plan's expenditures for activities that improve health care quality, and fraud prevention activities.

the state implemented several interventions to improve asthma care. Interventions that addressed social determinants included referring members to the Green and Healthy Homes Initiative to conduct home assessments of asthma triggers and minimizing barriers to transportation by providing transportation to office appointments, providing prescription pharmacy delivery, and offering asthma adherence monitoring through retail pharmacies.[51]

To improve the state's performance on the Postpartum Care Visit Core Set measure (PPC-AD), Michigan conducted a quality improvement project called the Maternal Infant Health Project (MIHP) that used a health equity focus, identifying racial or ethnic disparities in the PPC visit rate and identifying strategies to improve health equity. Four of Michigan's 13 Medicaid health plans implemented enhanced care coordination and transportation benefit interventions. For example, they created a transportation worksheet which prompted plans to consider how the health plan, pilot clinics, and maternal infant health programs would refer patients for transportation scheduling assistance and how to track the transportation services. Women who participated in MIHP were 1.5 times more likely to receive an appropriately timed postpartum care visit than women who did not participate. This is important because the postpartum visit offers an important opportunity to (1) assess a woman's physical recovery from pregnancy and childbirth, (2) provide breastfeeding support, (3) manage preexisting or emerging chronic health conditions, (4) evaluate her psychological and mental health status, and (5) discuss family planning options and set the stage for well-women care between pregnancies.

F. Program of All-Inclusive Care for the Elderly (PACE)[52]

Description: Authorized under sections 1894 and 1934 of the Act and codified in regulation at 42 CFR part 460, the Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. Payment to PACE organizations is capitated, and provides PACE organizations with a single monthly payment in exchange for delivering all the services a participant needs rather than providing compensation only for those services covered under Medicare and Medicaid.

PACE benefits also include all other services determined necessary by the participant's interdisciplinary team to improve and maintain a participant's health. PACE organizations provide services in an adult day health center as well as through in-home and referral services in accordance with the participant's needs.

Who Is Eligible: Medicaid beneficiaries can generally join PACE if they meet certain conditions:

- Age 55 or older;
- Live in the service area of a PACE organization;
- Require a nursing facility level of care; and

[51] External Quality Review Table 15. Progress on Childhood Asthma Performance Improvement Projects (PIPs), as Reported in External Quality Review (EQR) Technical Reports, 2018–2019 Reporting Cycle (n = 9 states, 23 PIPs) available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2018-2019-chart-pack.zip (zip file).
[52] For more information on PACE, see https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html.

- Be able to live safely in the community.

How PACE Can Address SDOH: An interdisciplinary team assesses each participant's needs, develops care plans, and delivers coordinated care and services. The interdisciplinary team meets to ensure that the comprehensive medical and social needs of each participant are met. Teams typically meet daily to discuss the status of participants. At a minimum, the team is composed of:

- Dietician;
- Driver;
- Home care coordinator;
- Registered nurse;
- Occupational therapist;
- PACE center manager;
- Personal care attendant;
- Physical therapist;
- Primary care provider;
- Recreational therapist or activity coordinator; and
- Masters-level social worker.

The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care. PACE's comprehensive benefit package includes (but is not limited to) all Medicare and Medicaid covered services.[53] Among other benefits, this includes: meals and nutritional counseling,[54] social work services, and transportation.[55]

State Example: Upham's Corner Elder Service Plan, a PACE organization based in Dorchester, MA, partnered with the Mayor of Boston in an initiative to target chronically homeless seniors who have been without a home for a year or more and had some level of disability. This year, the PACE organization enrolled eight seniors who were matched with housing and approved for support services -- all in one day. The PACE team works closely with housing managers to address issues as they arise so participants do not face the loss of housing.

[53] See 42 C.F.R. § 460.92. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c06.pdf for more information.
[54] Under 42 C.F.R. § 460.78, the PACE organization must ensure, through the assessment and care planning process, that each participant receives nourishing, palatable, well-balanced meals that meet the participant's daily nutritional/medical and special dietary needs. The PACE organization must provide nutrition support to meet the daily nutritional needs of a participant, if indicated by his or her medical condition or diagnosis. Nutrition support includes tube feedings, total parenteral nutrition, or peripheral parenteral nutrition if indicated by the participant's medical condition or diagnosis.
[55] Pursuant to 42 C.F.R. §§ 460.76 and 460.106, transportation must be provided as indicated in a participant's plan of care.

Other Opportunities under Medicaid and CHIP to Address SDOH[56]

1. Integrated Care Models

Description: Integrated care models are care delivery and payment models that reward coordinated, high quality care.[57] Integrated care models can include patient-centered medical homes (PCMHs), accountable care organizations (ACOs), or other models that emphasize person-centered, continuous, coordinated, and comprehensive care. These models typically include partnerships with community-based organizations, social service agencies, counties, and public health agencies.

How Integrated Care Models Can Address SDOH: Integrated care models can support a variety of innovative approaches to addressing individuals with complex SDOH needs, such as interdisciplinary care teams and comprehensive care coordination services, while providing flexibility for states to develop payment mechanisms that support intensive care interventions such as tiered rate methodologies and shared savings models.

Although there is no specific current statutory authority for ACOs within the Medicaid program, CMS released two letters to state Medicaid directors in 2012, providing guidance regarding Medicaid integrated care models, including ACOs and ACO-like models for payment and service delivery reform.[58] CMS also released guidance in a Center for Medicaid and CHIP Services Informational Bulletin in 2013, "*Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality,"* clarifying how care delivery models such as integrated care models can help states and Medicaid providers to meet the complex needs of the highest utilizers of acute care in Medicaid populations.[59] Furthermore, integrated care approaches have been shown to improve health outcomes for individuals with behavioral health conditions. The Medicaid Innovation Accelerator Program (IAP) provides materials and resources on physical and mental health integration here.

States typically use a per member per month (PMPM) payment model, with or without quality or cost incentives, in PCMH models, while they use shared savings and/or shared risk models, with quality requirements and/or incentives, to create a financial incentive for providers to

---

[56] The information presented is not necessarily a complete list of all other opportunities to address SDOH under Medicaid and CHIP. For example, it does not include a discussion of current or future Center for Medicare and Medicaid Innovation (CMMI) Models that test models that incorporate strategies to address SDOH, as these are time-limited interventions and may not be available to states that are not currently participating. It also does not include a discussion of the ways in which states can partner with other state or local entities to implement coordinated strategies to address SDOH, as an extensive review of these strategies was beyond the scope of this letter. CMS is, however, available to provide technical assistance to states that would like assistance related to these or other topics.

[57] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf

[58] Centers for Medicare & Medicaid Services. "Integrated Care Models." July 10, 2012. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/SMD-12-001.pdf; Centers for Medicare & Medicaid Services. "Policy Considerations for Integrated Care Models." July 10, 2012. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf.

[59] Centers for Medicare & Medicaid Services. "Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality." July 24, 2013. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf.

deliver value over volume in ACO models. In some models, ACOs can also receive a PMPM payment to provide services and accept full financial risk for the health of their assigned or attributed population. CMS allows states considerable flexibility in structuring payment mechanisms for PCMH, ACO, and ACO-like models and encourages states to move from volume-based FFS reimbursement to integrated care models with financial incentives to improve beneficiary health outcomes.

State Example: Under Rhode Island's Medicaid Managed Care Organizations sub-contract with Accountable Entities (which are integrated provider organizations responsible for the total cost of care and healthcare quality and outcomes of an attributed population), Accountable Entities must demonstrate the capacity to address SDOH, and they must identify three key domains of social need for each population that will advance the state's three identified priority areas: housing insecurity, food insecurity, and safety and domestic violence.[60]

2. CHIP Health Services Initiatives (HSI)

Description: States have the option under title XXI to develop state-designed HSIs to improve the health of low-income children. HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in the regulations at 42 CFR § 457.10. Both direct services and public health initiatives are permitted under the statute and regulations. An HSI must directly improve the health of low-income children[61] less than 19 years of age who are eligible for CHIP and/or Medicaid, but may serve children regardless of income. In addition, to the extent possible, the state should use its efforts through an HSI to enroll eligible but unenrolled children in Medicaid or CHIP.

States finance the non-federal portion of HSI expenditures, and the federal portion is funded through a state's available CHIP allotment for a fiscal year, as determined under section 2104 of the Act. HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under section 2105(c)(2)(A) of the Act, claims for HSIs and administrative expenses together cannot exceed 10 percent of the total amount of title XXI funds claimed by the state each quarter. Within the 10 percent limit, states must fund costs associated with administration of the CHIP state plan first; any funds left over may be used for an HSI, subject to the 10 percent cap. In addition, states must assure in the CHIP state plan that they will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds. States should be able to demonstrate that they have a process for coordinating with other federal agencies and other federal funds.

How CHIP Health Services Initiatives Can Address SDOH: Many of the SDOH described in this letter have been or could be addressed through CHIP HSIs. For example, states have used HSIs for lead abatement projects in the homes of Medicaid and CHIP eligible children, home visits and environmental modifications (e.g., high-efficiency particulate air filters) to reduce asthma triggers, emergency food relief for families, and youth violence prevention programs in schools and community-based organizations.

---

[60] RIte Care Core MCO Contract Sections 1.127 and 2.01.0

[61] As defined in 42 CFR Section 457.10, a low-income child means a child whose household income is at or below 200 percent of the federal poverty line for the size of the family involved.

State Example: New York's CHIP HSI (SPA #23) provides emergency food relief and nutrition services to food-insecure children receiving services through the Hunger Prevention Nutrition Assistance Program. The goal of the program is to increase access to safe and nutritious food and related resources, to develop and provide nutrition and health education programs, and to empower people to increase their independence from emergency food assistance programs.

3. Administrative Procedures

Description: Federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potentially eligible individuals into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan, when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity.

How Administrative Procedures Can Address SDOH:

- *Collaboration with Community-Based Programs*

Medicaid and CHIP can be an integral part of a collaboration with other community-based programs, including state and local housing agencies, social service organizations, programs funded by the Administration for Community Living,[62] programs funded by the Administration for Children and Families,[63] public health agencies, faith-based organizations, and other community-based entities that support an individual's ability to live and receive needed care in their chosen community setting. The effectiveness of these activities is based on collaboration across the many entities that serve low-income individuals with SDOH needs. State Medicaid agencies employing individuals to perform partnership building, such as with No Wrong Door System (NWD)[64] lead agencies in the aging and disability networks, and collaboration activities may claim the 50 percent administrative claiming rate for these activities if the costs can be recognizable as allowable Medicaid administrative costs and only to the extent that the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles. For example, to address the housing needs of beneficiaries, a state could claim administrative match for activities, such as:

[62] These programs include Area Agencies on Aging, Centers for Independent Living, and Aging and Disability Resource Centers, funded under the Older Americans Act and the Rehabilitation Act. See, *Strategic Framework for Action*, https://acl.gov/sites/default/files/programs/2020-06/ACL_Strategic_Framework_for_Action_v1_%20June%202020_final_508_v2.pdf.

[63] For example, the Community-Based Child Abuse Prevention (CBCAP) program (authorized by title II of the Child Abuse Prevention and Treatment Act (as amended by Public Law 115-271)) awards funding annually to every state, the District of Columbia, and Puerto Rico to support community-based efforts to implement effective family support and child maltreatment activities. More information on CBCAP can be found at www.friendsnrc.org.

[64] The State Medicaid Agency is part of the state's Aging & Disability Resource Center/No Wrong Door (ADRC/NWD) System. Person centered counselors, a key part of a state's ADRC/NWD System, facilitate assessment and service plan develop using a process that takes into account the individual's full array of resources, service needs, and service availability See also NWD System Medicaid Claiming Guidance and Tools. See https://nwd.acl.gov/sustaining-a-nwd-system.html.

- Developing formal and informal agreements and working relationships with state and local housing and community development agencies to help beneficiaries access existing and new housing resources;
- Participating and contributing to the planning processes of state and local housing and community development agencies by collecting (e.g., through beneficiary surveys or claims data) and providing demographic, housing needs, and other relevant data for Medicaid eligible populations; and
- Coordinating with available housing locator systems or listings, and developing and/or coordinating data tracking systems to include information on the availability of affordable and accessible housing.

Administrative activities are focused on coordination between various agencies to increase access to community-based resources, in contrast to activities focused on helping beneficiaries connect to community resources such as housing or employment opportunities.

- *Data Integration and Information Sharing*

Integrated information systems and data sharing capabilities at the state level are critical to supporting the evolving role of states in assuring appropriate, accessible, and cost-effective care for individuals with complex social needs. Medicaid offers a variety of pathways to support the design and development of statewide data and analytic infrastructure to address SDOH. Leveraging Medicaid resources to support data integration and data sharing can assist state health systems to identify individuals with SDOH needs and link them to appropriate medical and social support services.

Enhanced federal Medicaid matching funds (at 90 percent) are available for state expenditures to design, develop, install, or enhance Mechanized Claims Processing and Informational Retrieval Systems and (at 75 percent) to operate such systems, under section 1903(a)(3)(A)(i) and (B) of the Act and 42 C.F.R. part 433, subpart C.

States are reminded that 42 CFR §§ 433.112(b)(16) and 433.116(c) require, as a condition of receiving enhanced federal matching funds under 1903(a)(3)(A)(i) and (B) of the Act, that the Medicaid mechanized claims processing and information retrieval system be interoperable with human services programs, health information exchanges, and public health agencies, as applicable.

In considering the technical infrastructure needed to administer programs focused on addressing SDOH among Medicaid beneficiaries, states should leverage any existing state and federal investments in care coordination hubs, such as Area Agencies on Aging,[65] which coordinate and offer services that can help older adults remain in their homes, or Aging and Disability Resource Centers,[66] which provide objective information, advice, counseling, and assistance to help older adults, people with disabilities, and their family members, regardless of income, with accessing LTSS. These entities are already well established across the country and have existing relationships with a broad range of local community-based resources that can help to address SDOH among Medicaid beneficiaries. Medicaid investments in connections and interoperability

[65] https://acl.gov/programs/aging-and-disability-networks/area-agencies-aging
[66] https://acl.gov/programs/aging-and-disability-networks/aging-and-disability-resource-centers

with such systems can be supported with enhanced federal financial participation, subject to all applicable federal requirements, including compliance with the cost allocation principles in 45 C.F.R. part 75, subpart E. In developing these connections, states are reminded of previous guidance explaining that states could comply with certain conditions of receiving enhanced federal matching funds under section 1903(a)(3)(A)(i) and (B) of the Act by implementing Open Application Program Interfaces (APIs) in the Medicaid enterprise.[67] Additionally, pursuant to 42 CFR 433.112(b)(12), as a condition of receiving enhanced federal matching funds under section 1903(a)(3)(A)(i) and (B) of the Act, states must ensure alignment of their mechanized claims processing and information retrieval system with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health Information Technology in accordance with 45 CFR part 170, subpart B. CMS also encourages states to review the Interoperability Standards Advisory (ISA) published by the Office of the National Coordinator, which includes standards for representing food insecurity, housing insecurity, transportation insecurity, and other social data.[68] Similarly, states are encouraged to review and participate in the ongoing work of the U.S. Department of Health and Human Services (HHS) supported Gravity Project[69] which convenes developers and users of SDOH data in efforts to find consensus for future national standards.

States should keep in mind that appropriate and effective investments in state health information technology (health IT) can be an important component of a state's SDOH activities and strategy, and can be particularly helpful with regard to facilitating data integration and information sharing between the state and providers.

- *Outreach and Enrollment*

One way to efficiently connect individuals who are eligible for Medicaid or CHIP to other benefits that can address SDOH, such as the Supplemental Nutrition Assistance Program (SNAP), is by implementing multi-benefit applications. These applications may provide a streamlined opportunity to connect a beneficiary to multiple state benefits, thereby enhancing access to these benefits and increasing awareness of other benefit programs. Multi-benefit applications, in accordance with 42 CFR § 435.907, may be used as an alternative Medicaid application so long as the application collects sufficient information to make a modified adjusted gross income (MAGI)-based determination and applicants are not required to answer questions not needed to make a determination for health coverage if they are not applying for any other benefit programs.[70]

States can also use various enrollment strategies[71] to make it easier for eligible individuals to enroll in Medicaid and CHIP coverage, including presumptive eligibility, "Express Lane" eligibility, continuous eligibility for children, and facilitating access to covered Medicaid

[67] https://www.medicaid.gov/federal-policy-guidance/downloads/smd16010.pdf
[68] https://www.healthit.gov/isa/social-psychological-and-behavioral-data
[69] https://www.hl7.org/gravity/
[70] Guidance regarding Medicaid application development is located at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/state-alt-app-guidance-6-18-2013.pdf.
[71] For additional information on these and other enrollment strategies, see https://www.medicaid.gov/medicaid/enrollment-strategies/index.html.

services for eligible individuals prior to and after the period of time spent in a correctional facility:

- Presumptive eligibility is a strategy that states employ to facilitate enrollment of individuals who are likely eligible for Medicaid or CHIP to access services without having to wait for their full application to be processed. States may authorize "qualified entities" – health care providers, community-based organizations, hospitals and schools, among others – to screen for Medicaid and CHIP eligibility and immediately enroll eligible individuals.
- States may rely on eligibility information from "Express Lane" agency programs to streamline and simplify enrollment and renewal in Medicaid and CHIP. Express Lane agencies may include SNAP, School Lunch programs, Temporary Assistance for Needy Families (TANF), Head Start, and the Women, Infant, and Children's program (WIC), among others. States can also use state income tax data to determine Medicaid and CHIP eligibility for children.
- States may provide children with 12 months of continuous coverage through Medicaid and CHIP, even if the family's income changes during the year. Guaranteeing ongoing coverage ensures that children receive appropriate care, and helps doctors develop relationships with children and their families. This option eliminates cycling on and off of coverage during the year. This also reduces state time and money that would be spent on unnecessary paperwork and preventable care needs.
- The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration. If the individual meets all applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility. Once enrolled, however, the state may place the inmate in a suspended eligibility status during the period of incarceration, or it may suspend coverage.[72]

4. Medicare Savings Programs (MSPs)

Description: Low-income Medicaid beneficiaries who are also enrolled in Medicare can qualify for Medicaid coverage of Medicare Part B premiums[73] through the state-administered Medicare Saving Programs (MSPs).

How Medicare Savings Programs Can Address SDOH: For many individuals who qualify, enrollment in a Medicare Savings Program expands their effective income by 10% or more – income that can be used to buy food, access transportation, and stabilize housing. As such, MSPs functionally address SDOH by giving beneficiaries more control over how they use their resources to address their needs. However, in many states, enrollment of eligible Medicare beneficiaries in MSPs is low.[74] As described in SMDL # 18-012,[75] states have opportunities to

[72] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf
[73] https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles
[74] https://www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/
[75] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

streamline eligibility determination and enrollment into MSPs in ways that would reduce administrative burden and could improve the economic security of millions of Medicare beneficiaries.

5. Money Follows the Person Demonstration

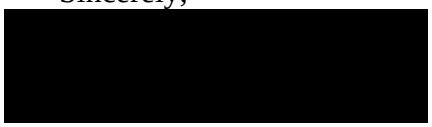
Description: The Money Follows the Person demonstration, first authorized by Congress as part of the Deficit Reduction Act in 2005 and since extended several times, is a long-standing grant-funded initiative designed to shift Medicaid's LTSS spending from institutional care to HCBS. Program goals include: increasing the use of HCBS and reducing the use of institutionally-based services; eliminating barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people receive LTSS in the settings of their choice; strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and putting procedures in place to provide quality assurance and improvement of HCBS.

How Can the Money Follows the Person Demonstration Address SDOH: Money Follows the Person provides critical tools to address gaps in the availability of community services for Medicaid-eligible individuals with disabilities and older adults. For example, Money Follows the Person grantees have built partnerships with housing agencies to increase the supply of housing options and resources, established community transition programs, and piloted the use of new services and supports (e.g., tenancy supports services, paying for one-time transition costs such as security deposits) to determine if they help to promote community living.

Closing

CMS remains committed to partnering with states to address beneficiaries' SDOH through the appropriate use of the Medicaid and CHIP programs. When used in accordance with statutory and regulatory requirements, Medicaid and CHIP can be effective tools to lower health care costs, improve health outcomes, and increase the cost-effectiveness of health care services and interventions for Medicaid and CHIP beneficiaries. CMS encourages states to pursue innovative payment and delivery system approaches, along with strong quality oversight and evaluation strategies, to achieve these goals. If you have questions about this guidance, please contact Jennifer Bowdoin, Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Programs Group at jennifer.bowdoin@cms.hhs.gov.

Sincerely,



Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
Section 1905(a) State Plan Authority	**Rehabilitative Services Benefit** (section 1905(a)(13) and 42 CFR § 440.130(d))	Individuals who meet any state-defined medical necessity criteria for covered services.	Regain skills and functioning to address SDOH; peer supports to assist with linking to social supports and services.
	Rural Health Clinics (RHCs)/ Federally Qualified Health Centers (FQHCs) (section 1905(a)(2)(B), 1905(a)(2)(C), and 1905(*l*)(1) and (2)	Individuals who meet any state-defined medical necessity criteria. This is a mandatory benefit for the categorically needy.	Screen individuals to identify social needs, collect and analyze SDOH data to inform interventions, and co-locate social services, as long as these activities are delivered as part of a Medicaid-covered RHC/FQHC service.
	Case Management/ Targeted Case Management (sections 1905(a)(19) and 1915(g) and 42 CFR §§ 440.169 and 441.18)	Individuals who meet any state-defined medical necessity criteria. States can provide targeted case management services to specific populations and limit the services geographically.	Linking/coordinating /referring to medical, educational, social, and other services; comprehensive care planning.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
HCBS Options	**Section 1915(c) HCBS Waiver**	Individuals who meet the state's institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID); need for services must be based on an assessed need and identified in a state-approved service plan. States can target waivers to specific populations and limit waivers geographically.	Service coordination or case management, home accessibility adaptations, one-time community transition costs, housing and tenancy supports, habilitation services, non-medical transportation, home delivered meals, supported employment services, assistive technologies to facilitate communication, "other" types of services that may assist in diverting individuals from institutional placement and supporting community living for eligible individuals.
	Section 1915(i) HCBS State Plan	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community. Needs-based criteria are factors used to determine an individual's requirements for support that can only be ascertained for a given person through an individualized evaluation of need and may include but cannot only include state-defined risk factors, such as risk of or experiencing homelessness, risk of food insecurity for individuals with diabetes, or risk of social isolation for older adults with chronic conditions. Services must be offered state-wide, but states can target the services to specific populations.	See section 1915(c) waivers.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority		Who Is Eligible	Examples of How the Authority Can Address SDOH
	Section 1915(j) Optional Self-Directed Personal Assistance Services	Individuals eligible for state plan personal care services or for a section 1915(c) waiver program.	Expenditures for goods and services, supports, or supplies related to a need or goal identified in the individual's state-approved person-centered service plan.
	Section 1915(k) Community First Choice State Plan	Individuals who meet the state's institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID). Services must be offered state-wide.	Expenditures for transition costs (such as first month's rent and utilities, bedding, and basic kitchen supplies) necessary for an individual transitioning from an institutional setting to a home and community-based setting; and expenditures relating to a need that increases an individual's independence or substitutes for human assistance, to the extent that Medicaid expenditures would otherwise be made for human assistance.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
Section 1115 Demonstration	States have significant flexibility in how to define target populations for demonstration services/activities, which should be available based on individual assessments of need as defined by the state. States can target services geographically and/or to populations meeting defined characteristics. States can test incentives that provide a pathway to coverage for certain individuals who may not be eligible for Medicaid through the state plan by requiring participation in work or other community engagement as a requirement for Medicaid eligibility or for receipt of additional Medicaid benefits. This allows individuals to opt into Medicaid coverage or receive enhanced benefits.	Case management/care coordination; tenancy supports; one-time transition costs; non-medical transportation; home delivered meals; supported employment. States have flexibility to provide other state-defined direct services to address SDOH, subject to CMS approval. Employment can help to lift low-income individuals and families out of poverty and, in doing so, address a broad range of social needs that can impact health. As discussed in SMDL 18-002, CMS supports states' efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.[1] These measures may also enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services (including those that address SDOH) and populations they cover, thereby maintaining the long-term fiscal sustainability of a state's Medicaid program.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
Section 1945 Health Home	Beneficiaries who: (1) have two or more chronic conditions; (2) have at least one chronic condition and are at risk of developing another; or (3) have at least one serious and persistent mental health condition. States can target eligibility for services based on a beneficiary's chronic conditions, but are not permitted to limit the benefit to specific age groups. The population must include all categorically needy individuals who meet the state's criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver), and at state option may include individuals in any medically needy group or section 1115 demonstration population.	Comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; individual and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
Managed Care Programs (Sections 1115(a), 1932(a), 1915(a), and 1915(b))	Individuals who meet any state-defined medical necessity criteria for the services covered under the contract.	Depending on the authority used, examples include case management/care coordination; tenancy supports; one-time transition costs; non-emergency medical transportation; home-delivered meals; supported employment; other direct services to address SDOH. For those services the state has existing Medicaid authority to cover (e.g. state plan), the state can incorporate those as contractual requirements on the plan and incorporate into the actuarially sound capitation rates. Otherwise, states can explore coverage as an in-lieu of service or plans may voluntarily provide as a value-added service, provided all regulatory requirements are met. States can also leverage managed care quality requirements, including Quality Strategies, quality assessment and performance improvement (QAPI) requirements, and external quality review to incentivize managed care plans to address SDOH.

Appendix A: Key Federal Authorities that Can Address Social Determinants of Health (SDOH)

Federal Medicaid Authority	Who Is Eligible	Examples of How the Authority Can Address SDOH
Program of All-Inclusive Care for the Elderly (PACE) (sections 1894 and 1934 and 42 CFR part 460)	Individuals who: are age 55 or older; live in the service area of a PACE organization; require a nursing facility level of care; and are able to live safely in the community.	Comprehensive care coordination and management, meals and nutritional counseling, social work services, transportation, and all other services determined necessary by the enrollee's interdisciplinary team to improve and maintain an individual's health.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Housing-Related Services and Supports				
Home Accessibility Modifications	Temporary or permanent changes to a home's interior or exterior structure to improve individuals' ability to remain in their homes and community, if they choose.	Depending on unique structural characteristics, temporary modifications could include the installation of a wheelchair ramp outside the home or grab bars in the shower. Permanent modifications could include enlarging a doorway to allow wheelchair passage.	Children with special health care needs, adults with disabilities, older adults	Section 1905(a)(7) home health benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(j) optional self-directed personal assistance services; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934; CHIP HSIs.

[76] The services and supports listed in this table align with those discussed in the section on "Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH" and do not necessarily include all opportunities available under Medicaid and CHIP to address SDOH. See "Opportunities to Address SDOH under Medicaid and CHIP Authorities" for information on additional opportunities.
[77] See "Opportunities to Address SDOH under Medicaid and CHIP Authorities" and Appendix A for more information on the eligible populations and other information on what is allowable related to the services and supports under each applicable federal authority.
[78] Please note that all of the illustrative examples may not be coverable under all of the authorities listed in each row of this table.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
One-Time Community Transition Costs	Help to facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence	Security deposits, utility activation fees, and essential household furnishings.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k) Community First Choice; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Housing and Tenancy Supports: Pre-tenancy Services	Assist individuals to prepare for and transition to housing	Conducting an individualized screening and community integration assessment that identifies the individual's preferences and any barriers to community residence; developing a community integration plan based on the community integration assessment; assisting with the housing search and application process, consistent with the community integration assessment and plan; ensuring that housing units are safe and ready for move-in; assisting in arranging for and supporting the details of move-in; and connecting the individual to community-based resources that provide assistance with activities such as securing required documents and fees needed to apply for housing and making any reasonable accommodation request(s) related to the individual's disability to a housing provider.	Adults with disabilities, older adults	Section 1905(a)(19) case management benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Housing and Tenancy Supports: Tenancy Sustaining Services	Tenancy sustaining supports are provided once an individual is housed to help the person achieve and maintain housing stability	Providing early identification and intervention for any behaviors that may jeopardize housing; education or training on the role, rights, and responsibilities of the tenant and landlord; connecting the individual to community resources to maintain housing stability; and individualized case management and care coordination (e.g., connecting the individual with needed Medicaid and non-Medicaid service providers and resources) in accordance with the person-centered care plan and the individual housing support plan.	Adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; CHIP HSIs; PACE under sections 1894 and 1934.
Non-Medical Transportation	Can enable individuals receiving home and community-based services to gain access to HCBS, activities, and resources	Transportation to grocery stores and places of employment.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Home-Delivered Meals	Help to address the nutritional needs of older adults and individuals with disabilities who need Medicaid-funded home and community-based services (HCBS)	No more than two meals per day provided to older adults in a state's HCBS waiver program.	Adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Educational Services	Help children with disabilities achieve their educational goals. Under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child's individualized education plan (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP).	Personal care services, physical or occupational therapy services provided to children by qualified providers in a school setting.	Children with special health care needs, young adults with disabilities	Various section 1905(a) state plan benefits (such as the rehabilitative services benefit in section 1905(a)(13)); section 1915(c) HCBS waiver (services may not duplicate those required under IDEA); section 1915(i) state plan (services may not duplicate those required under IDEA).

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Supported Employment	Ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting	Customized employment, job coaching to provide supports and services not specifically related to job skill training that enable the individual to successfully integrate into the job setting (e.g., instruction on how to ameliorate the impacts of a mental illness on the job), and personal care services to provide assistance at an individual's place of employment.	Adolescents, working age adults with disabilities	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1115 demonstration; managed care programs.
Community Integration and Social Supports	Medicaid-funded HCBS provide opportunities for Medicaid beneficiaries to choose to receive services in their home or community rather than institutions	Instruction on how to utilize public transportation, companion services to accompany an individual with disabilities into places in the community.	Children with special health care needs, adults with disabilities, older adults	Section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k); section 1115 demonstration; managed care programs; PACE under sections 1894 and 1934.

Appendix B: Examples of Services and Supports that Can Be Covered under Medicaid and CHIP to Address SDOH[76]

Services and Supports	Description	Illustrative Examples	Potential Target Populations	Federal Authorities that May Be Able to Cover the Services and Supports[77,78]
Case Management	Assists eligible individuals to gain access to needed medical, social, educational, and other services	Assessment and linkages to needed services provided to individuals who are homeless or at risk of homelessness.	Children with special health care needs, adults with disabilities, older adults	Section 1905(a)(19) state plan case management benefit; section 1915(c) HCBS waiver; section 1915(i) HCBS state plan; section 1915(k); section 1115 demonstration; section 1945 health home; managed care programs; PACE under sections 1894 and 1934; CHIP HSIs.

Medicaid's Role in Housing

The relationship between housing and health is well established. Poor housing conditions can worsen health outcomes related to infectious and chronic disease, injury, and mental health, and may also affect childhood development through exposure to harmful toxins such as lead. Individuals experiencing homelessness or housing instability (for example, difficulty paying rent or frequent moves) also have difficulty obtaining health care and managing complex health conditions. Data suggest that among those who are chronically homeless, the provision of supportive housing—not increased access to case management or other outpatient health services—led to a decrease in emergency department use (Moore and Rosenheck 2017).

Medicaid and supportive housing programs serve many of the same individuals, yet collaboration between the two has been limited in the past. As states focus attention on addressing social determinants of health (SDOH), however, Medicaid programs are increasingly collaborating with state and local housing authorities to assist beneficiaries in need of supportive housing. The importance of such efforts has been underscored by the COVID-19 pandemic, which has contributed to housing instability, and a growing recognition that communities of color are disproportionately affected by social and economic impediments to health.

This issue brief describes how Medicaid programs pay for housing-related services. It begins by reviewing relevant subregulatory guidance issued by the Centers for Medicare & Medicaid Services (CMS) and the various federal Medicaid authorities under which states can cover housing-related services. It provides examples of how certain states braid multiple funding sources to provide supports for certain populations, and also discusses the use of health services initiatives (HSIs) under the State Children's Health Insurance Program (CHIP) to identify lead exposure and fund abatement.

Federal Guidance on Use of Medicaid Funds for Housing

Medicaid programs can pay for housing-related services that promote health and community integration such as assistance in finding and securing housing, and home modifications when individuals transition from an institution to the community. However, Medicaid cannot pay for rent or for room and board, except in certain medical institutions (CMS 2021a). CMS guidance on housing-related services focuses on supporting states' ability to comply with legal rulings to promote community integration for people with disabilities; approaches for providing housing-related services and supports; and ways in which states can reduce lead exposure for low-income children using CHIP HSIs.

Resources to support Olmstead implementation

In its 1999 *Olmstead v. L.C.* ruling, the United States Supreme Court held that the unjustified institutionalization of individuals with disabilities is a violation of the Americans with Disabilities Act (ADA, P.L. 101-336).[1] Under the ADA, people with disabilities are guaranteed equal opportunity to access all public programs, including the right to live in the most integrated setting appropriate to their needs. Medicaid supports community integration as the primary payer of long-term services and supports (LTSS).

In 2012, CMS issued an informational bulletin to states highlighting housing resources that can be used in coordination with Medicaid to support Olmstead implementation, including the Section 811 Project Rental

Assistance (PRA) program. This program, run by the U.S. Department of Housing and Urban Development (HUD), provides integrated supportive housing for people with disabilities (CMS 2012). PRA funds are awarded to state housing agencies that set aside units in affordable housing developments. To receive PRA funds, state housing grantees are required to partner with state Medicaid programs to identify and refer low-income individuals with disabilities to PRA units and ensure their access to LTSS within the community (HUD 2018).

Housing-related services and activities

In 2021, CMS released a letter to state health officials describing circumstances under which Medicaid and CHIP funds can be used to pay for services to address SDOH, including housing-related services and supports. This letter supersedes the CMS informational bulletin on housing-related services issued in 2015.[2] It does not provide new flexibilities, but outlines how states can address housing (and other SDOH) under existing authorities. The letter describes housing-related services in three categories: home accessibility modifications, one-time community transition costs, and housing and tenancy supports (CMS 2021a) (Table 1). States can use a number of different authorities to cover these services.

TABLE 1. Medicaid Housing-Related Services and Supports

Housing related service or support	Definition	Examples
Home accessibility modifications	Temporary or permanent changes to a home's interior or exterior to help beneficiaries remain in their homes.	• installing a wheelchair ramp outside the home • adding grab bars in the shower • enlarging a doorway to allow wheelchair passage
One-time community transition costs	Payment of expenses to establish basic living arrangements when beneficiaries transition from institutional or other congregate settings (e.g., a homeless shelter) to a private residence.	• paying security deposits and utility activation fees • purchasing essential household furnishings

TABLE 1. (continued)

Housing related service or activity	Definition	Examples
Housing and tenancy supports	Pre-tenancy services to help beneficiaries transition to housing, and tenancy sustaining supports once beneficiaries are housed.	*Pre-tenancy services* • conducting a tenant screening and housing assessment that identifies the beneficiary's preferences and barriers related to successful tenancy • assisting with the housing application process and housing search • ensuring that housing units are safe and ready for move-in • assisting in arranging for and supporting move-in, including related transportation and moving expenses *Tenancy sustaining services* • identifying and addressing behaviors that may jeopardize housing (e.g., lease violations) • education and training on the role, rights, and responsibilities of the tenant and landlord • individualized case management and care coordination (e.g., connecting the individual with Medicaid and non-Medicaid service providers and resources)

Source: CMS 2021a.

Lead abatement

In 2017, CMS released a set of frequently asked questions on HSI funds that states can use to pay for certain public health activities, including lead abatement. Allowable lead abatement activities include the removal, enclosure, or encapsulation of lead-based paint and lead dust hazards; the removal and replacement of surfaces or fixtures, which can include water service lines and other fixtures identified during an environmental investigation as lead hazards; the removal or covering of soil lead hazards; and training to ensure there is a sufficient number of qualified workers to complete lead abatement activities (CMS 2017a).

Relevant Medicaid Authorities for Covering Housing-Related Services

States can use several different federal authorities to pay for housing-related services, particularly for individuals transitioning to the community from institutional settings. This section describes various authorities and provides examples of how states are using them to provide housing supports and services.

Money Follows the Person demonstration

The Money Follows the Person (MFP) demonstration, authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), has provided $3.7 billion to 43 states and the District of Columbia to help Medicaid

beneficiaries transition from institutions back to the community (HHS 2017). Until recently, eligibility was limited to Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days.[3] The Consolidated Appropriations Act of 2021 (P.L. 116-260) reduced the minimum stay requirement to 60 consecutive days in an institutional setting, which may include days admitted for short-term rehabilitative services. Beneficiaries receive additional home- and community-based services (HCBS) under the demonstration beyond what is provided under a state's existing HCBS programs, including housing supports.

MFP states have also partnered with public housing authorities to provide housing choice vouchers to beneficiaries which can be used to secure housing within the community.[4] More than 101,000 people with chronic conditions and disabilities transitioned from institutions back into the community through MFP programs between 2008 and 2019 (CMS 2021b). The program was set to expire at the end of 2018; however, Congress authorized new funding through fiscal year (FY) 2023.[5] States can roll over unused funds for four subsequent fiscal years (§ 6071 of the DRA). Therefore, FY 2023 funds will be available for expenditures through FY 2027.

Section 1115 waiver demonstrations

Several states cover housing-related activities or services for Medicaid beneficiaries through demonstration waivers authorized under Section 1115 of the Social Security Act (the Act). Such demonstrations are initially approved for five years and must be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in the absence of the waiver. Some Section 1115 demonstrations, including those in Illinois and New Jersey, focus on addressing housing insecurity for high-cost, high-need beneficiaries, such as individuals with serious mental illness. Other demonstrations, including those in California and North Carolina, are broader efforts to address housing as well as other social determinants of health, such as nutrition, transportation, and interpersonal violence.

Under the Medi-Cal 2020 demonstration, California provides housing supports to certain beneficiaries through its Whole Person Care pilots (California DHCS 2016).[6] Depending on the design of the pilot program, eligible beneficiaries can receive housing-based care management and tenancy supports including assistance in finding and securing housing, coverage for certain move-in costs, and minor home modifications. A majority of the 25 pilot programs offer such services to individuals at risk of or experiencing homelessness and those with a demonstrated medical need for housing and supportive services, such as individuals with behavioral health needs. Services are delivered in coordination with managed care organizations, the public housing authority, and community-based organizations. Pilot programs may also connect beneficiaries to permanent housing opportunities through the use of a county-wide housing pool (Pagel et al. 2019).[7] In Los Angeles County, which administers the largest pilot, 60 percent of program funding is targeted to individuals who are experiencing or at-risk of homelessness, many of whom have behavioral health conditions (HHS 2020, California DHCS 2017).[8]

Section 1915(b) managed care waivers

States can use savings achieved under Section 1915(b) waivers to provide additional services, including housing-related services, to beneficiaries enrolled in managed care. In some states, this includes services to help beneficiaries with disabilities, older adults needing LTSS, and those experiencing chronic homelessness identify, transition to, and sustain housing. For example, under a Section 1915(b) waiver, North Carolina offers Medicaid coverage for supportive services that help individuals with serious and persistent mental illness transition into the community. Individuals with mental health needs or substance use disorders (SUDs) may use peer supports as part of individualized recovery services aimed at developing skills for housing, employment, and self-management. The waiver also specifically provides the

authority for Medicaid coverage of transitional living skills such as housekeeping, shopping, and laundry services for children under age 21 with certain behavioral health diagnoses (CMS 2013a).

Section 1915(c) home- and community-based services waivers

States may use Section 1915(c) waivers to pay for housing transition and tenancy-sustaining services for beneficiaries who would otherwise be served in settings such as a nursing facility. These include the costs of services needed to establish a basic household such as environmental modifications, security deposits required to obtain a lease, moving expenses, and essential household furnishings. Such services may only be provided to the extent that they are reasonable and necessary as determined through development of the beneficiary's service plan and only when the beneficiary is unable to meet the expenses or obtain the services elsewhere.[9]

Most states (46) operate at least one Section 1915(c) waiver to deliver housing-related services such as assistance transitioning into community-based living, home modifications, and one-time moving expenses (MACPAC 2020). For example, the Louisiana Department of Health, in partnership with the state's housing authority, operates a permanent supportive housing program financed through multiple federal and state funding streams, including Medicaid.[10] Multiple Section 1915(c) waivers help the state provide pre-tenancy, tenancy crisis, and tenancy-maintenance services, whereas Medicaid state plan services focus on mental health rehabilitation, including community psychiatric supportive treatment and psychosocial rehabilitation.

Individuals must have a substantial, long-term disability (which may be physical, developmental, or behavioral) and have a need for housing and tenancy support to participate in Louisiana's supportive housing program.[11] Eligibility is not limited to Medicaid beneficiaries, though many are served by the program; Medicaid pays for tenancy supports for 67 percent of program participants (CSH 2017).

Minnesota uses four different Section 1915(c) waivers to provide housing-related services, among other HCBS, to individuals with traumatic brain injuries, developmental and physical disabilities, and those with chronic illness. Waiver services and supports help Medicaid-eligible individuals transition into community living and include coverage for certain expenses related to moving, finding a home, developing a housing plan, and building skills in how to be a tenant and negotiate with landlords. Minnesota also covers home modifications such as wheelchair ramps, widening doors, and stair lift installation, limiting payment for eligible modifications to $40,000 per beneficiary per service year (MACPAC 2020, Jopson and Regan 2016).

Many states use Section 1915(b) waivers jointly with Section 1915(c) waivers. For example, Ohio implemented joint Section 1915(b) and 1915(c) waivers to provide HCBS, including housing supports, for individuals age 18 years and older who are eligible for Medicare and Medicaid, require either a hospital or nursing facility level of care, and reside in a participating county.[12] Covered services include non-recurring set-up expenses (e.g., furniture, food preparation items) for individuals who are transitioning from an institutional setting or another provider-operated living arrangement to a private residence (CMS 2019).

Section 1915(i) home- and community-based state plan benefit option

Section 1915(i) of the Act allows states to offer housing-related services that are similar in nature to those offered under Section 1915(c); however, beneficiaries do not have to meet an institutional level of care and the state cannot place a limit on the number of individuals served.

States may use this state plan option to provide housing-related services to adults with behavioral health conditions, or those who would not otherwise qualify under a Section 1915(c) waiver. Texas uses this authority to pay for home modifications, transition assistance, and long-term recovery support services for

adults with serious mental illness. Services include minor home modifications, transition assistance, supervised living services, and supportive home living (CMS 2020a). Under Section 1915(i), North Dakota provides pre-tenancy and tenancy sustaining services to individuals who could be safely transitioned from an institutional setting to a lower level of care, individuals who are at risk of institutionalization, and those who are experiencing or at risk of homelessness (CMS 2020b).

Section 1905(a) state plan services

Section 1905(a) of the Act gives states the authority to provide services under the Medicaid state plan for individuals transitioning from institutions, or trying to obtain or maintain housing in the community. An example of such a service is targeted case management, which can assist beneficiaries in gaining access to needed medical, social, educational, and housing services. Typically, case managers work with beneficiaries to assess their needs, devise a plan, and either provide services or connect them to resources for other non-covered services. Case managers are required to monitor and follow up with beneficiaries on their progress.

In Minnesota, case managers help clients reach housing services and resources, often by connecting them to specialized agencies and organizations (Minn. Stat. § 245.462 (2017)). Connecticut offers targeted case management to individuals with SUD and co-occurring mental illness to help beneficiaries find a place to live or keep current housing, and to assist in monitoring their budgets to ensure they can maintain their housing, though providers do not directly budget for an individual or pay bills on behalf of the beneficiary (Connecticut DMHAS 2017).

Section 1945 health home state plan option

Section 1945 of the Act allows states to establish health homes to integrate physical and behavioral health and LTSS for individuals with certain chronic conditions. Among other service requirements, health homes must provide comprehensive transitional care from inpatient to other settings, as well as referrals to social services and supports. States receive enhanced federal matching funds for health home services for an initial period. As of December 2020, 21 states and the District of Columbia operated 37 health home models targeting beneficiaries with behavioral health conditions, HIV/AIDS, and other chronic conditions (CMS 2020c).[13]

A number of health homes provide housing resources for Medicaid beneficiaries (HHS 2020). For example, under Maine's health home for individuals with opioid use disorder, providers conduct a comprehensive clinical assessment upon intake, which includes assessing beneficiary needs related to housing. Health home providers also make referrals to address identified social service needs, including assistance accessing and maintaining safe and affordable housing (CMS 2017b).

Section 1915(k) Community First Choice state plan optional benefit

Community First Choice (CFC), authorized under Section 1915(k) of the Act, allows state Medicaid programs to pay for services and supports identified as a part of person-centered care plans. Such plans are developed with the beneficiary and document the specific type of care the beneficiary will receive. States receive a 6-percentage point increase in federal matching payments for CFC state plan expenditures (CMS 2021).

Under CFC, states may cover transition costs for individuals moving from an institution to a home or community-based setting, including security deposits for an apartment or utilities, basic bedding or kitchen supplies, and other one-time expenses. CFC may also cover costs related to home modifications when specified in an individual's person-centered care plan to increase independence or substitute for human

assistance. As of FY 2018, eight states—California, Connecticut, Maryland, Montana, New York, Oregon, Texas, and Washington—were using Section 1915(k) state plan authority (Watts et al. 2020).

Health Services Initiatives

States can use some of their CHIP funding to implement health services initiatives (HSIs) that improve the health of low-income children under the age of 19 who are eligible for CHIP or Medicaid (42 CFR 457.10).[14] HSIs must directly address the health of children eligible for Medicaid or CHIP but may serve children regardless of household income (CMS 2017a). States are also encouraged to use an approved HSI to enroll eligible but unenrolled children in Medicaid or CHIP.[15]

Generally, the HSIs approved by CMS have addressed services related to public health interventions and prevention, such as poison control and youth violence prevention (CMS 2017a). However, some states, including Michigan and Maryland, are using HSIs to address and reduce childhood lead poisoning, including through lead abatement activities.[16] States seeking approval to implement such activities must meet certain criteria such as using state-certified individuals to perform abatement services that have been proven to be effective in removing lead hazards. The program must be time-limited. Because there are no statewideness requirements for CHIP, states may target their lead abatement programs to specific communities that have been heavily affected by lead exposure.

To respond to the crisis associated with lead tainted water in Flint, Michigan, the state received approval in 2016 for a Section 1115 demonstration to expand Medicaid coverage for pregnant women and children who are or were served by the Flint water supply between April 2014 and a date to be determined in the future.[17, 18] To complement that demonstration, CMS approved an HSI authorizing $24 million per year for five years to reduce lead hazards in Flint and other parts of the state. Activities approved under the HSI include removing lead-based paint and lead dust hazards; removing and replacing surfaces or fixtures identified as lead hazards; removing or covering soil lead hazards; pre- and post-abatement testing activities; and workforce training (CMS 2016).

Maryland's Medicaid program partnered with the Department of Environment and the Department of Housing and Community Development to implement an HSI in state FY 2018 to reduce lead poisoning and improve asthma treatment. The HSI's two-pronged approach includes expanded lead identification and abatement, and environmental case management for certain Medicaid and CHIP beneficiaries. Children under the age of 19 who are enrolled in or may be eligible for CHIP or Medicaid and who have elevated blood lead levels are eligible for services. Properties in which an eligible child resides or spends more than 10 hours a week can be assessed for the presence of lead. This includes rental properties, owner-occupied properties, and residential day care facilities. If the presence of lead is found, a lead abatement contractor will remediate the property and abatement will be confirmed by a lead inspector. In select jurisdictions, children enrolled in or eligible for Medicaid or CHIP who are diagnosed with persistent moderate to severe asthma and those with elevated blood lead levels are able to receive additional case management services (Maryland DOH 2017).

Endnotes

[1] Olmstead v. L.C., 119 S. Ct. 2176 (1999).
[2] Whereas the 2015 CMS informational bulletin focused exclusively on housing, the 2021 CMS state health official letter on SDOH addresses housing-related services as well as non-medical transportation, home-delivered meals, educational services,

supported employment, community integration and social supports, and case management. The letter also outlines overarching requirements states must meet when providing services to address SDOH (CMS 2021, CMS 2015).

[3] For purposes of the demonstration, institutions include nursing homes, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases for individuals 65 and older, inpatient psychiatric facilities for individuals under the age of 21, and hospitals (HHS 2017).

[4] The housing choice voucher program, commonly referred to as Section 8, is the federal government's program for assisting low-income families, people over age 65, and people with disabilities to receive safe housing in the private housing rental market (CMS 2012). In 2011, HUD allocated housing choice vouchers to 28 public housing authorities in 15 states. Housing authorities were required to partner with its state health and human services agency or the state Money Follows the Person demonstration program (Lipson et al. 2014).

[5] The MFP demonstration was most recently extended by the Consolidated Appropriations Act of 2021 (P.L. 116-260), which appropriated $450 million in federal funding for each of FY 2021, FY 2022, and FY 2023.

[6] The demonstration provides up to $3.0 billion for the pilot, $1.5 billion of which come from federal Medicaid matching funds and $1.5 billion from local funds provided through intergovernmental transfers. To participate in the pilot program, lead entities—which are usually county government agencies—must apply to the California Department of Health Care Services. Lead entities are required to work with other community organizations including managed care plans and the public housing authority to demonstrate how non-Medicaid covered services, such as room and board, will be paid for under the pilot (California DHCS 2017a).

[7] A flexible county-wide housing pool is one suggested way to pay for housing under the pilots. This pool may include Whole Person Care pilot payments for housing-related deliverables for which Medicaid payment is available, as well as assistance such as rental subsidies that are not eligible for federal Medicaid matching funds (CMS 2018).

[8] The program includes five types of services to help homeless participants with medical needs gain access to housing. The five services are homeless care support services; recuperative care, which includes the provision of short-term residential care for homeless participants in need of housing and supports while they recover from acute illnesses or injuries; sobering centers; tenancy support services; and benefits advocacy, which includes social supports and enrollment assistance for public benefits (LACDHS 2017).

[9] Service planning for beneficiaries in programs authorized under Sections 1915(c) and 1915(i) of the Social Security Act (the Act) must be person-centered and address health and LTSS needs in a manner that reflects an individual's preferences and goals. The service planning process is directed by the beneficiary and may include a representative that the individual has freely chosen to contribute to the process. A person-centered plan includes individually identified goals and preferences, such as those related to community participation, employment, income and savings, health care and wellness, and education. The plan should reflect the services and supports the beneficiary receives (paid and unpaid), who provides these services and whether the beneficiary chooses to self-direct services.

[10] Other federal funding streams that support Louisiana's housing partnership include grants from the Health Resources Service Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Veterans Administration (VA) (Wagner 2017).

[11] Priority is given to individuals transitioning from institutions and homeless individuals or households (CSH 2017).

[12] Ohio's Section 1915(b) waiver mandates enrollment in managed care for eligible beneficiaries, though beneficiaries may opt out of the plan for Medicare benefits. The state's Section 1915(c) waiver outlines the covered services (CMS 2013b).

[13] California, Connecticut, Delaware, District of Columbia, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, and Wisconsin operate Medicaid health homes under the state plan. Several states and the District of Columbia have multiple health homes to target specific populations, such as those with serious mental illness or HIV/AIDS (CMS 2020c).

[14] For the purposes of an HSI, low-income child means a child whose household income is at or below 200 percent of the federal poverty level (CMS 2017a).

[15] Section 2105(a)(1)(D)(ii) of the Act gives states the option to use CHIP funds to develop an HSI to improve the health of low-income children through direct services or public health initiatives (CMS 2017a). HSIs are funded through the states' CHIP allotments, but are subject to the same cap applicable to administrative expenses: 10 percent of the total amount states spend on CHIP health benefits. States must first fund their administrative costs; after that any remaining funds under the cap can be used for HSIs. States receive the CHIP matching rate for HSIs.

[16] Lead poisoning has severe implications for childhood development. It can lead to behavioral, endocrine, and cardiovascular conditions, as well as learning difficulties and a decline in IQ. All children enrolled in Medicaid are required to receive blood lead screening tests at ages 12 months and 24 months. Moreover, any child between age 24 and 72 months with no record of a previous blood lead screening test must receive one. Separate CHIPs do not have the same requirements for universal lead screenings as Medicaid, although states are encouraged to align their CHIP and Medicaid screening policies (CMS 2017a).

[17] Michigan's Section 1115 demonstration expanded coverage for pregnant women and children up to age 21 with incomes up to and including 400 percent of the federal poverty level (FPL). Those with incomes over 400 percent FPL may buy into the program to receive full Medicaid benefits (CMS 2016).

[18] On December 21, 2020, CMS approved a temporary extension of Michigan's Section 1115 demonstration, which currently expires on February 28, 2022 (CMS 2020d).

References

California Department of Health Care Services (DHCS). 2017. *Whole Person Care basic statistics: California Whole Person Care pilot applications.* Sacramento, CA: DHCS. http://www.dhcs.ca.gov/provgovpart/Documents/WPCApplicationStats.pdf.

California Department of Health Care Services (DHCS). 2016. *Whole Person Care program: Medi-Cal 2020 waiver initiative.* Sacramento, CA: DHCS. http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. Letter from Anne Marie Costello to state health officials regarding "Opportunities in Medicaid and CHIP to address social determinants of health (SDOH)." January 7, 2021. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021b. Money Follows the Person. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. Section 1915(i) of the Social Security Act Medicaid state plan amendment: Adult mental health home and community-based services state plan benefit renewal. August 31, 2020. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/spa/downloads/TX-20-0003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Section 1915(i) of the Social Security Act Medicaid state plan amendment: New North Dakota home and community-based services state plan benefit. December 31, 2020. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/spa/downloads/ND-20-0010.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. *Medicaid health homes: An overview.* Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020d. Section 1115 of the Social Security Act Medicaid demonstration: Temporary extension of the Flint Michigan Section 1115 demonstration. December 21, 2020. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-health-impacts-potential-lead-exposure-cms-temp-ext-12212020.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. OH Integrated Care Delivery System (1035.R00.00). Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/OH1035.zip.

Centers for Medicaid and Medicare Services (CMS), U.S. Department of Health and Human Services. 2018. *California Medi-Cal 2020 demonstration special terms and conditions.* Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf.

Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017a. *Frequently asked questions: Health services initiative.* Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017b. Section 1945 of the Social Security Act Medicaid state plan amendment: Opioid health home services approval. Baltimore, MD: CMS. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ME/ME-17-0006.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Michigan health services initiative. November 14, 2016, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/fact-sheets/michigan-health-services-initiative.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Center for Medicaid and CHIP Services (CMCS) informational bulletin regarding "Coverage of housing-related activities and services for individuals with disabilities." June 26, 2015. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. North Carolina Cardinal Innovations. Section 1915(b) waiver: State of North Carolina, NC MH/IDD/SAS health plan NC-02.R04.M02 amendment. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/NC_Cardinal-Innovations_NC-02.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Center for Medicaid and CHIP Services (CMCS) informational bulletin regarding "New housing resources to support Olmstead implementation". June 18, 2012. Baltimore, MD: CMS. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-18-12.pdf.

Connecticut Department of Mental Health and Addiction Services (DMHAS). 2017. *Targeted case management.* Hartford, CT: DMHAS. http://www.ct.gov/dmhas/cwp/view.asp?q=577794.

Corporation for Supportive Housing (CSH). 2017. *Tenancy support services in Medicaid.* New York, NY: CSH. http://www.csh.org/wp-content/uploads/2017/01/Health_SummaryStateAction_TenancySH_Services_-2017_01.pdf.

Hargan, E. 2017. *Report to the President and Congress: The Money Follows the Person demonstration.* Washington, DC: U.S. Department of Health and Human Services. https://www.medicaid.gov/sites/default/files/2019-12/mfp-rtc.pdf.

Jopson, A. and C. Regan. 2016. *Bringing independence home: Housing-related provisions under Medicaid 1915(c) home- and community-based services waivers.* Boston, MA: Center for Consumer Engagement in Health Innovation and Community Catalyst. https://www.communitycatalyst.org/resources/publications/document/Bringing-Independence-Home_Housing_Releated_HCBS-1915c-Waivers.pdf.

Kaiser Family Foundation (KFF). 2012. *State health facts. Medicaid benefits: Targeted case management.* Washington, DC: KFF. https://www.kff.org/medicaid/state-indicator/targeted-case-management/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Kingsley, G. T. 2017. *Trends in housing problems and federal housing assistance*. Washington, DC: the Urban Institute. https://www.urban.org/sites/default/files/publication/94146/trends-in-housing-problems-and-federal-housing-assistance.pdf.

Los Angeles County Department of Health Services (LACDHS). 2017. Whole Person Care—Los Angeles (WPC-LA). Los Angeles, CA: LACDHS. http://dhs.lacounty.gov/wps/portal/dhs/!ut/p/b1/04_Sj9Q1NjI2NDY0MzXUj9CPykssy0xPLMnMz0vMAfGjzOLdDAwM3P2dgo0MTE3MDBy9QkNC3IMsDPxNzYEKIpEVWJj6ORk4GpiY-lt4mBg6mxoQ0h-uH4WqBN0EU0IKDKAKDHAARwN9P4_83FT93KgcS88sE0UAAy82wQ!!/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0YwMDBHT0JTMjBNTDMwQVJUQkVHSVAwQzk0/.

Maryland Department of Health (DOH). Letter from Dennis R. Schrader to Edward K. Kasemeyer and Maggie McIntosh regarding "2017 Joint chairmen's report (p. 87)—Report on efforts to reduce lead poisoning and the incidence of asthma in children enrolled in Medicaid." November 7, 2017. https://mmcp.health.maryland.gov/Documents/JCRs/2017/Lead%20Poisoning-Asthma%20Reducing_Final.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. Compendium of Medicaid home- and community-based services waiver waiting list administration. August 2020. https://www.macpac.gov/wp-content/uploads/2020/08/Compendium-of-Medicaid-HCBS-Waiver-Waiting-List-Administration.xlsx.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Letter from Penny Thompson to Orin Hatch, Greg Walden, Alex Azar II, Ron Wyden, and Frank Pallone Jr. regarding "Money Follows the Person rebalancing demonstration report to the President and Congress." March 29, 2018. https://www.macpac.gov/wp-content/uploads/2018/03/MACPAC-Comment-Letter-on-HHS-MFP-Report-to-Congress.pdf.

Moore, D. T. and R.A. Rosenheck. 2017. Comprehensive services delivery and emergency department use among chronically homeless adults. *Psychological Services*, 14(2), 184–192. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5424614/pdf/nihms836696.pdf.

Musumeci, M. 2017. *Key themes in Medicaid Section 1115 behavioral health waivers.* Washington, DC: Kaiser Family Foundation. http://files.kff.org/attachment/Issue-Brief-Key-Themes-in-Medicaid-Section-1115-Behavioral-Health-Waivers.

Pagel L., C. Backstrom, and H. Haycock. 2019. *Whole person care: A mid-point check-in.* Sacramento, CA: Harbage Consulting, the California Health Care Foundation, and the California Department of Health Care Services. https://www.aurrerahealth.com/wp-content/uploads/2020/05/Harbage_WPC_MidPointPaper.pdf.

U.S. Department of Health and Human Services (HHS). 2020. Report to Congress. *Innovative state initiatives and strategies for providing housing-related services and supports under a state Medicaid program to individuals with substance use disorders who are experiencing or at risk of experiencing homelessness.* November 13, 2020. Washington, DC: HHS. https://www.hhs.gov/medicaid/benefits/downloads/rtc111320-1017.pdf.

U.S. Department of Health and Human Services (HHS). 2017. *Report to the President and Congress: The Money Follows the Person rebalancing demonstration*. Washington, DC: HHS. https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf.

U.S. Department of Housing and Urban Development (HUD). 2018. Section 811 Project Rental Assistance (PRA) program. Washington, DC: HUD. https://www.hudexchange.info/programs/811-pra/.

Wagner, R. 2017. *Louisiana permanent supportive housing.* Presentation before the National Academy for State Health Policy annual conference, October 2017, Portland, OR. https://nashp.org/wp-content/uploads/2017/06/R-Wagner-19.pdf.

Watts, M. O., M.B. Musumeci, and P. Chidambaram. 2020. *Medicaid home and community-based services: Enrollment and spending.* Washington, DC: Kaiser Family Foundation. https://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending.

THE INTERSECTION OF LONG-TERM CARE AND HOUSING

Stetson University

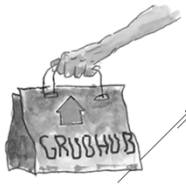
National Conference on Special Needs Planning and Special Needs Trusts

Blaine P. Brockman, Esq.
Darby Legal Assistance
765 Lakeview Drive
West Jefferson, Ohio 43162
blaine@darbylegal.org
(614) 296-6391

1

Test Your Knowledge

Do you know how to get Medicaid to have this installed?
How about *Medicaid paying for this service*?



2

Test Your Knowledge

You'll never be a know-it-all

a. There are many programs

b. Various agencies are running them

c. They can be private, private, or combined

3

LTCSS The 3-legged

Care
- a. Some means by which the resident can provide themselves healthcare or day to day attendant care

Money or some substitute
- a. Some means of purchasing necessities like food, clothing, furnishings, travel, entertainment, etc.

Shelter (often overlooked)
- a. Shelter must be affordable, accessible, located correctly (e.g. near public transportation, safety services, sources of food, etc.).

4

How to Learn about Housing

Tips and Advice

Build relationships with the big players to discover the housers
- a. They will be in more than one place

Then build relationships with the housers
- a. They will vary by program

Volunteer with housing organizations
- a. Get to now the operation and the 'tricks'

5

The Community Housing Paradigm

Think about housing differently than you are
- a. It's not all Section 8

Don't quit when you find a waiting lists
- a. Projects
- b. Special Vouchers
- c. Not invariably linked to HUD housing

Housing managers and builders cobble together resources

Learn how to "sniff out" program

6

The Role of Medicaid

Olmstead v. LC 1999
a. Foundation of the right to receive services in the community

Social Determinants of Health (SDOH)
a. State Director Letter 2021
   • Major implications for Medicaid
b. This program relies heavily on this document

Waiver and State plan (and mixed)
a. Some waivers draw on state plan money

7

CMS Approved Housing Expenditures
3 Major Categories

Expenses in transitioning from institutional setting

Tenancy sustaining support

Modifications

8

Money Follows the Person

Provides Medicaid funding for people residing in a facility setting who are transitioning to a community setting

To be eligible, one must:
a. Be enrolled in Medicaid
b. Resided in a facility for 60 consecutive days
c. Actively transitioning to a community setting

There may be state specific criteria as well

9

Using Medicaid Waivers

1115 Demonstration waivers

1915(b) Managed care waivers

1915(c) HCBS waivers
a. The one you surely know

1915(i) Using state plan dollars for ABD
a. See rule of construction

1915(j) Self directed personal assistance services (PAS)

1915(k) Community First Choice state plan

10

Using Medicaid Waivers

1115 Demonstration waivers

1915(b) Managed care waivers

1915(c) HCBS waivers
a. The one you surely know

1915(i) Using state plan dollars for ABD
a. See rule of construction

1915(j) Self directed personal assistance services (PAS)

1915(k) Community First Choice state plan

11

Using Medicaid State Plan

Section 1905 state plan services

Note: These may look and smell different than waiver services

a. What housing services that might be available
   - Rehabilitation – e.g. regaining skills necessary for community living
   - Targeted case management – e.g. building a plan for integration

12

HUD Housing
HOTMA

Changes in Eligibility Rules
a. HUD is not requiring HOTMA compliance until July, 1, 2025
b. See HUD Notice H 2023–10 as updated for guidance

Trust distributions from an irrevocable trust that is not controlled by a family member…
a. Are income to the family if they were income to the trust
b. Are not income to the family if they came from principle

Hard asset cap at $100,000
a. Revocable trusts are always an asset

13

HUD Housing
Some advantages for elders and people with disabilities

Reduction in income of $525, indexed to inflation

Reductions from countable income
a. Unreimbursed medical expenses exceeding 10% of income
   - These expenses include costs of caregivers and equipment necessary to maintain employment
   - Costs of related to equipment, property modifications, assistance animals and attendant care that allow a person with a disability perform day-to-day tasks independently

Income of a live-in aid is not included in family income

14

HUD Housing
Specific Housing Types and Vouchers

Section 811 Supportive Housing for People with Disabilities

Section 202 Supportive Housing for the Elderly

Two specialized vouchers for people with disabilities
a. Section 8 Mainstream
   - Historically underutilized
   - Requires active advocacy
b. Non-elderly disabled (NED) vouchers
   - Often wrapped into the Mainstream voucher pool

15

THANK YOU!

QUESTIONS?

Blaine P. Brockman, Esq.
Darby Legal Assistance
765 Lakeview Drive
West Jefferson, Ohio 43162
blaine@darbylegal.org
(614) 296-6391

16


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

Medicaid Waivers: The Intersection of State and Federal Law

STETSON LAW

Center for Elder Justice

Access and Justice For All®

MEDICAID WAIVERS:

The Intersection of State and Federal Law

By: G. Mark Shalloway

Medicaid waivers play a crucial role in supporting individuals with disabilities by providing access to tailored healthcare services. The Federal government, though specific sections of the Social Security Act, allows states to implement Medicaid waivers, enabling them to offer customized care to more effectively meet the needs of their populations.

What is the Medicaid Waiver Program

The Medicaid Waiver programs were conceived by the Federal government to allow states to modify the standard Medicaid rules under Sections 1115 and Section 1915 of the Social Security Act. Section 1115 allows states to create and test experimental, pilot, or demonstration programs, with the goal of improving quality, accessibility, and efficiency of care. Section 1915(c) allows states to deliver health care services to aged or disabled adults who require nursing home level of care, but do not want to live in a traditional nursing home or institutional setting. Section 1915(b) waivers allow states to create managed care delivery systems or otherwise restrict the choice of providers for Medicaid beneficiaries. States can use this waiver to more efficiently coordinate care and control costs.

Eligibility Criteria

Medicaid's basic criteria are financial and based on medical need. The financial requirements are based on income, assets, and transfers. Currently, the income is capped at $2,829.00 per month gross for each person applying. A married couple who are both applying can have a gross income of $5,658.00. There is no income limit for a spouse who is not applying for Medicaid. An individual's assets are capped at $2,000.00 and a married couple's assets are capped at $3,000.00. Homestead property with equity of up to $713,000.00, one car,

personal belongings and household items, and prepaid burial plans and burial plots are not countable assets. A non-applicant spouse's assets are capped at $154,140.00.

Additionally, within the 5 years prior to date when the application for Medicaid is approved, the applicant must report any transfers of more than $1,000.00 which were not for fair market value of goods or services. In addition to the Federal Medicaid requirements, each state may have different requirements for their state Medicaid and Waiver programs. (https://www.myflfamilies.com/sites/default/files/2024-03/Appendix-A-9.pdf)

Florida Waiver Programs

Florida has been proactive in implementing waiver programs. By far, the largest of these is the Statewide Medicaid Managed Care (SMMC) Long Term Care program, which is a concurrent 1915(b)(1) and 1915(b)(4) waiver. It is available to adults over 65 or to disabled persons, such as those with a brain injury, HIV/AIDS, physical disabilities, or those who are medically fragile and between the ages of 18-64, who meet the financial requirements for Medicaid. Florida also established Aging and Disability Resource Centers (ADRC's) to provide information, referral services, and assistance in applying for Medicaid and other programs. (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/FL)

Another example is the iBudget Waiver, which is a Section 1915(c) waiver that provides "person-centered" planning for individuals with developmental disabilities, over the age of three who meet the level of care criteria for intermediate care facilities for the developmentally disabled. This approach ensures that each person has an individualized support plan that is tailored to their specific needs, preferences, and goals. It is designed to promote independence

and community integration by providing a range of services including supported employment, residential habilitation, and adult day training. The iBudget program is implemented and administered by the Agency for Persons with Disabilities (ADP). (https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/developmental-disabilities-ibudget-waiver)

Long Term Social Services

The following services are included as a minimum benefit for anyone who qualifies for these waivers:

Adult Companion Care: Applicants can receive service from a home health care aide who assists with non-medical activities of daily living and personal care, such as bathing, eating, dressing, house-keeping, grocery shopping, cooking, transferring, toileting, etc. The amount of time is based on need as assessed by the healthcare provider. This service can be provided in the client's home or in an assisted living facility. The aides can be contracted by the health care provider or there is a consumer directed option, which allows the applicant to hire the provider of their choice. This can include spouses, children or other family members. The family member must complete a background check and training.

Adult Day Care: Adult Day Care is a service where adults who require supervision can spend part of a day, but less than 24-hours in an institutional group setting which can provide socialization and activities, but can also include meals, occupational therapy, medical screenings, classes, assistance with medicine and personal care, classes, and other services.

Durable Medical Equipment and Medical supplies: If prescribed, Medicaid will pay to buy or rent durable medical equipment, such as wheelchairs, walkers, prosthetics, orthotics, oxygen and related supplies, pulse oximeters and respiratory supplies, nebulizers, alternative communication devices, hospital beds and mattresses and rails, lifting and moving supplies, and toileting aides. If feasible, some repairs of durable medical equipment is also covered. Medicaid will also pay for medical supplies such as wound care, incontinence supplies, gloves and wipes, and diabetic supplies. Medicaid may also provide some home accessibility adaptations.

Nutritional Assessment and Meal Delivery: Patients and their caregivers can receive education and support for dietary requirements and meal planning. Additionally, prepared, frozen meals can be delivered to the home.

Respite Care: Caregivers can request care for their loved one for times that they cannot be there or need a break. Caregivers can also request training and counseling.

Transportation: Medicaid will reimburse for non-emergency transportation for doctor's appointments and Medicaid compensable services, generally with the existing public transit systems or taxis. This service is available to all Medicaid recipients who have no other means of transportation.

Personal Emergency Response System: Medicaid will provide a device, such as a life alert or other emergency response system and pay the monthly charge for use.

Therapy Services: Medicaid can provide occupational therapy, physical therapy, speech therapy, or respiratory therapy, if needed.

Mental Health Services: Medicaid will cover long term inpatient mental services, clinical therapy, individual and group therapy sessions, and treatment for some disorders, such as bipolar disorder.

Case Coordination/Case Management: Case managers ensure individualized programs that can meet the needs of clients and can help monitor when their needs change. They also can coordinate care with doctors, therapists, and other medical professionals.

Hospice Care: Medicaid will also provide in-home hospice care.

The waiver programs also can provide some at home medical assistance such as assistance with preparing and taking medication, and intermittent and continuing nursing services. (https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/florida-medicaid-s-covered-services-and-waivers)

How States Get Waiver Approval

Obtaining a Medicaid waiver is a multi-step process that begins with the state developing a detailed proposal that outlines the scope, eligibility criteria, services to be provided, and the budget for the waiver program. This proposal will ultimately be submitted to the Centers for Medicare & Medicaid Services (CMS) for review.

Prior to submitting the waiver proposal to CMS, the state must provide public notice and allow for public comment.[1] The notice and public comment period occurs twice: once at the state

[1] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7&field_hcbs_authority_target_id%5B8%5D=8

level and then again at the federal level.[2] These procedures ensure transparency and give stakeholders, including beneficiaries, healthcare providers, and advocacy groups, the opportunity to provide input on the proposed waiver.

At the state level, states must provide a public comment period prior to submitting an application to CMS for either a new demonstration program or an extension of an existing program. This information must be published prominently on either the main page of the state Medicaid website or a website established for the demonstration.[3] States will also publish the public notice in either the State's administrative record or in newspapers with the widest circulation and maintain an email mailing list or similar mechanism to notify interested parties of the demonstration application.[4]

The state-level public notice must include the following: (1) a comprehensive description of the application or extension "that contains a sufficient level of detail to ensure meaningful input from the public"; (2) "locations and Internet address where copies of the demonstration application are available for public review and comment"; (3) mail and email addresses where the public may send their written comments for review, and the thirty-day time period during which comments will be accepted; and (4) "[t]he location, date, and time of at least two public hearings convened by the State to seek public input on the demonstration application."[5]

The state is required to conduct at least two public hearings, to be held on separate dates and at separate locations, at least twenty days prior to submitting an application to CMS.[6]

---

[2] 42 C.F.R. § 431.408(a)(1)
[3] Id¡
[4] Id¡
[5] 42 C.F.R. § 431.408(a)(1)
[6] Id¡

Members of the public throughout the state must have an opportunity to provide comments at these hearings.[7] Additionally, during at least one of the two hearings, the state must provide telephonic or Web conference capabilities to ensure accessibility for anyone who wishes to participate and provide comment.[8]

Finally, federal regulation mandates additional responsibilities for states that are home to "[f]ederally-recognized Indian tribes, Indian health programs, and/or urban Indian health organizations.".[9] These states must consult with the Indian tribes or seek advice from the Indian health organizations and programs prior to submitting their applications to CMS if the project would have a direct effect on those tribes or health organizations and programs.[10]

The public notice and comment is required to be at least 30 days in length and upon completion of that period the state will submit an application to CMS.[11] When submitting their application to CMS, the state must include a summary of the public comments received during the public input process, and if any comments were not adopted, the reasons why.[12] Additionally, the state must specify in their application any modifications to the waiver that they made as a result of the public input process.[13] Once an application is received, CMS has 15 days to determine whether the application is complete.[14] CMS will send the state written notice informing the state of receipt of the complete application, the date on which the Secretary received the application, and the start date of the 30-day federal public notice period.[15] In the

[7] Id¡
[8] Id¡
[9] Id¡
[10] Id¡
[11] Id¡
[12] 42 C.F.R. § 431.408(a)(1)
[13] Id¡
[14] Id¡
[15] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7

event that CMS determines that the application is not complete, CMS will notify the state of any missing elements in the application.[16]

After the state is notified by CMS that their application is complete, the federal public notice and comment period commences. Like the state level process, the federal public notice and comment period will last at least 30 days and will allow the general public and stakeholders to submit comments.[17] CMS will publish on www.Medicaid.gov the state's application and associated documents and it will receive public comments through that website.[18] CMS will also post all public comments and maintain an electronic mailing list to notify interested parties that a state's demonstration application is available on the website.[19]

In order to allow enough time for CMS to consider all written public comments, CMS will not render a final decision until 15 days, at a minimum, after the conclusion of the federal public comment period.[20] While CMS will continue to accept comments beyond the 30-day period, they cannot guarantee that comments received after the 30-day comment period will receive adequate consideration due to the need for timely federal review of a state's request and as a result, CMS strongly encourages comments to be submitted within the 30-day federal comment period.[21]

After conclusion of the federal notice and comment period, CMS conducts a thorough review of the waiver proposal to ensure it meets federal requirements and aligns with the goals of the Medicaid program. In determining whether the waiver would further the objectives of

---

[16] Id.
[17] 42 C.F.R. §§ 431.416(a), 431.412(b)(1)-(2)
[18] Id.
[19] Id.
[20] Id.
[21] Id.

Medicaid, CMS typically reviews whether the changes would accomplish at least one of the following: increase coverage for low-income people; increase access to care; improve health outcomes; or increase the efficiency and quality of care through delivery system changes.[22]

Additionally, a fundamental requirement that CMS looks for when reviewing an application is cost-neutrality.[23] This means that the cost of providing services under the waiver must not exceed the cost of providing the same services under the traditional Medicaid program.[24] States must demonstrate compliance with this constraint by providing a calculation based on hypotheticals and projections that illustrates what the Medicaid spending would be without the waiver and that the federal spending with the waiver is at least equal to or below the without waiver base.[25]

When granting Medicaid waiver applications, CMS favors those that offer services otherwise not available under traditional Medicaid programs. This concept, referred to as "service flexibility" incudes services such as case management, personal care, respite care and environmental modifications.[26]

CMS' review process also focuses on making sure the state's application will result in services that benefit specific populations, such as individuals with intellectual or developmental disabilities, the elderly, or those with chronic illnesses.[27] By focusing on the unique needs of these populations, states can provide more effective and appropriate care.

---

[22] https://crsreports.congress.gov/product/pdf/R/R43357
[23] Id¡
[24] Id¡
[25] Id¡
[26] https://crsreports.congress.gov/product/pdf/R/R43357
[27] Id¡

After rendering a decision, CMS will maintain and publish on its website an administrative record which will include the demonstration application, public comments sent to CMS and, if the application is approved, the final special terms and conditions, and the state's acceptance letter.[28] This rule is final, and will be effective 60 days after publication.[29]

The Reality of Waitlists

States can cover home and community-based services (HCBS) in their state plans, which require such benefits to be made available to all enrollees, or through various waiver authorities that can be targeted to certain populations. Waivers are often used by states to cover HCBS and permit states to limit the number of individuals.[30] A state's ability to cap the number of people enrolled in HCBS waivers can result in waiting lists when the number of people seeking services exceeds the number of waiver slots available. Waiting lists reflect the populations a state chooses to serve, the services it decides to provide, the resources it commits, and the availability of workers to provide services.[31] While waiting lists allow states to manage costs, they also restrict access to HCBS for some individuals who need them. When faced with long wait times, some individuals are left having to find other ways of meeting their long term care needs.

States take various approaches to managing their HCBS waiver waiting lists and eligibility screening for waiver services happens at different times in different states, making it

[28] Id¡
[29] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7
[30] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/
[31] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

difficult to compare waiting lists across states.[32] In 2023, individuals on waiting lists waited an average of 36 months to receive HCBS waiver services, down from 45 months in 2021.[33] The length of a state's waiting list can be influenced by that state's waiting list management approach.[34] In 2023, thirty-two states with waitlists screened individuals for waiver eligibility among at least one waiver, but even among those states, five states did not screen for all waivers.[35] There were six states that did not screen for eligibility among any waivers and those six states (Alaska, Illinois, Iowa, Oklahoma, Oregon, and Texas) account for over half of all the people on waiting lists.[36]

Among those states that screen, the first-come, first-served approach is the most common.[37] This approach encourages individuals to seek enrollment in anticipation of future needs.[38] A state's approach to waitlist management can produce different results depending on the specific waiver service being offered. With regards to waivers for people with intellectual or developmental disabilities, when states take a first-come first-served approach, families will often add their children to waiting lists at a very young age, assuming that by the time they

[32] Medicaid.™ .Child.Health.Ins¡.Program.Payment.™ .Access.Comm'n?State.Management.of.Home_.and. Community_Based.Services.Waiver.Waiting.Lists 0.(8686)?https¿--www¡macpac¡gov-wp_ content-uploads-8686-64-State_Management_of_Home_and_Community_Based_Services_Waiver_Waiting_ Lists¡pdf [perma¡cc-9S6L_FUPX]¡

[33] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[34] Medicaid.™ .Child.Health.Ins¡.Program.Payment.™ .Access.Comm'n?State.Management.of.Home_.and. Community_Based.Services.Waiver.Waiting.Lists 0.(8686)?https¿--www¡macpac¡gov-wp_ content-uploads-8686-64-State_Management_of_Home_and_Community_Based_Services_Waiver_Waiting_ Lists¡pdf [perma¡cc-9S6L_FUPX]¡

[35] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[36] Id¡

[37] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[38] Id¡

reached the top of the waiting list, their children would have developed the immediate need for services.[39]

With regards to categories of the population on waitlists, people with intellectual or developmental disabilities constitute almost three-quarters (72%) of the total waiver waiting list population.[40] Seniors and adults with physical disabilities account for one-quarter (25%), while the remaining share (3%) includes children who are medically fragile or technology dependent, people with traumatic brain or spinal cord injuries, people with mental illness, and people with HIV/AIDS.[41]

Even though waitlists are a reality for the vast majority of individuals seeking waiver services, most people on waiting lists are eligible for personal care provided through states' regular Medicaid programs or for services provided through specialized state plan HCBS benefits, which can help bridge the gap while they wait to be called off.[42]

[39] Id.
[40] Id.
[41] Id.
[42] Id.

Medicaid Waivers

The intersection of State and Federal Law

By: G. Mark Shalloway

1

Types of Waivers

Section 1115: Pilot programs for novel or experimental programs

Section 1119(b): Home or community based care for those who require nursing home level of care.

Section 1119(c): Managed Care Systems

2

Eligibility Requirements

Income limit:
$2,829/month (Individual)
$5,658/month (Married couple)
No limit (Well spouse)

Asset limit:
$2,000 (Individual)
$3,000 (Married couple)
$154,140 (Well spouse)

Required disclosure of transfers > $1,000 for prior 5 years

3

FL Waiver Programs

Statewide Medicaid Managed Care (SMMC) Long Term Care

* Adults 65+
* Disabled adults 18-65
* Require nursing home level care

iBudget

* Developmentally disabled
* Age 3+
* Qualify for intermediate level care

4

Available Services

Adult companion care	Respite care
Housekeeping	Transportation
Adult day care	Personal emergency device
Durable medical equipment	Therapy services
Medical supplies	Mental health services
Nutritional counseling	Case management
Meal delivery	Hospice care

5

Medicaid Waivers: The Application Process

6

Step One: State Proposal

The state submits a waiver proposal to the Centers for Medicare & Medicaid Services (CMS) detailing the following:

1. Scope
2. Eligibility
3. Services
4. Budget

7

Step Two: Public Notice & Comment

- State Level Public Notice & Comment
  - 30 days minimum
  - At least two (2) public hearings, at least 20 days apart
  - Additional responsibilities for states that are home to federally recognized Indian Tribes or Indian Health Organizations or Programs
  - Concludes with state submitting application to CMS
- Federal Level Public Notice & Comment
  - Begins after state notified that CMS application is complete
  - 30 day minimum
  - CMS renders final decision at least 15 days after conclusion of federal public comment period

8

Step Three: Federal Review

- CMS reviews the proposal ensuring it meets federal requirements and goals of Medicaid
- Key Considerations:
  - Cost-Neutrality
  - Targeted Populations
  - Service Flexibility

9

The Reality of Waiver Waitlists

- 2021: Average wait time of 45 months to receive HCBS waiver services
- 2023: Average wait time of 36 months to receive HCBS waiver services

- Contributing Factors to Waitlists
  - Does the state screen for eligibility?
    - Six (6) states that do not screen at all
  - If state screens, what screening method is used?
    - First come, first served
    - Priority
    - Combo of priority + first come, first served
    - Lottery

10


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®

STETSON LAW

LTSS Boot Camp
(Virtual)

November 8, 2024

Does Managed Care Work?

STETSON LAW

Center for Elder Justice

Access and Justice For All®

2024 National Conference on Special Needs Planning and Special Needs Trusts:

LTSS BOOTCAMP

Managed Care: Is it Working?

Will Lucius, J.D.
Chief Trust Officer
Raymond James Trust, N.A.

Will Lucius, J.D., a member of the State Bars of Florida, Michigan, and Wisconsin, is the Chief Trust Officer for Raymond James Trust, N.A., in St. Petersburg, Florida, where his department manages fiduciary accounts throughout the United States. Prior to this role, Will served as the Director of Special Needs Trusts at Raymond James Trust where his team was responsible for the administration of thousands of special needs and settlement preservation trusts across the nation. Will was also a practicing attorney in the areas of estate planning, long-term care planning, elder law, and disability rights representing clients throughout Michigan and Wisconsin. He is an adjunct professor at Stetson University College of Law in Gulfport, Florida, and speaks regularly on special needs planning and trust administration in state and national forums.

I. Introduction

Leading causes of death from the pre-colonial era throughout much of the 19th and early 20th centuries resulted from preventable yet deadly diseases such as smallpox, typhoid, influenza, and cholera, as well as numerous wars with high soldier mortality rates, all of which had a significant weighting effect on the average lifespan during this time.[1] Luckily, modern medicine morphed from rudimentary battlefield procedures conducted without sound sanitation and wound care practices to state-of-the-art experimental surgeries transplanting the heart of a pig into a terminally-ill patient.[2] Today, chronic and sustained illnesses like heart disease and cancer followed by unintentional injuries arising from modern lifestyles (i.e., automobile accidents, poisoning, drowning, and workplace injuries) are the deadly drivers of the day.[3] Consequently, the average life expectancy has grown exponentially from 39 years in 1860 to 77.5 years in 2024,[4] with the oldest living person currently 116 years-old.[5] And the infant mortality rate has declined at a similar speed from 399 deaths per 1000 live births to an impressive 7 per 1000 over this same period.[6] While this progress should give comfort to one seeking a long life it is also well documented that those living to advanced age may do so with chronic or other disabling conditions requiring the need for long-term services and supports (LTSS) to assist with one or more activities of daily living (ADLs), such as eating, bathing, toileting, or ambulating, whether at home or in some other setting.[7]

This steady march towards longer life supported by emerging medical technology, sophisticated healthcare procedures, and mass inoculation of vaccines, coupled with a reliance on

---

[1] Sarah Morin, *Disease in Colonial New England,* https://libguides.ctstatelibrary.org/archives/uncoveringnewhaven/blog/Disease-in-Colonial-New-England (last updated October 12, 2021).

[2] Lauran Neergaard, *Surgeons Perform Second Pig Heart Transplant,* https://apnews.com/article/pig-heart-transplant-d894f6ce27b7db71ecb0ec393cac3e86 (last updated September 22, 2023).

[3] Centers for Disease Control, *Leading Causes of Death,* https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm (last updated May 2, 2024).

[4] Centers for Disease Control, *Life Expectancy,* https://www.cdc.gov/nchs/fastats/life-expectancy.htm (last updated May 2, 2024).

[5] Guiness Book of World Records, *Oldest Living Person,* https://www.guinnessworldrecords.com/world-records/84549-oldest-person-living (last accessed September 2024).

[6] Aaron O'Neill, *Child Mortality Rate in the United States,* https://www.statista.com/statistics/1041693/united-states-all-time-child-mortality-rate/ (last updated August 9, 2024).

[7] Halli Heimbuch, *Prevalence and Trends of Basic Activities of Daily Living Limitations in Middle-Aged and Older Adults in the United States* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10660458/ (last updated November 9, 2023).

these advanced healthcare services to do so, comes at a very steep cost. Underlying this data is the accelerated rise in healthcare-related spending borne by both the patient and the nation writ large. Currently, the United States expends over $4 trillion dollars on healthcare representing almost 20% of the Gross Domestic Product (GDP), compared to just 2.2% of the GDP in the 1850s or 5% in the 1960s.[8] Yet, despite leading all nations in healthcare spending the U.S. reportedly wastes one-quarter of this spending and lags behind the top ten wealthiest nations both in health outcomes and public health services.[9]

This significant growth in healthcare spending has been crippling to the average U.S. consumer as well. Medical expenses are currently cited as the leading cause of household bankruptcies in the United States notwithstanding the number of Americans with some form of healthcare coverage rose from less than 10% pre-World War II to an astonishing 92% in 2023.[10] In colonial America, paying for an at-home birth with a midwife would take the form of bartering with readily available (often agricultural) resources. Now, one can expect a routine pregnancy to cost over $20,000 throughout the pregnancy, delivery, and postpartum care of the child, most of which is conducted in a medical setting.[11] At the other bookend, aging Americans in the 19th century would convalesce at home with support from immediate family, whereas, as of 2022 $467 billion was allocated to long-term care in the U.S. with out-of-pocket consumer costs on long-term care exceeding $63 billion.[12]

Considerations as to how much a patient pays for healthcare services, the amount a healthcare provider should charge for those services, who is responsible for payment once services are rendered, and the method or delivery of such service or payment has added an even further layer of complexity for our society to address and from which the U.S. health insurance

---

[8] Centers for Medicare and Medicaid Services, *Historical,* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,spending%20accounted%20for%2017.3%20percent (last updated September 10, 2024).

[9] Niharika Namburi, *Managed Care Economics,* https://www.ncbi.nlm.nih.gov/books/NBK556053/ (last updated January 30, 2023).

[10] Katherine Keisler-Starkey, *Health Insurance Coverage in the United States: 2022,* https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf (last updated September 2023).

[11] Elizabeth Rivelli, *How Much Does It Cost to have a Baby? 2024 Averages,* https://www.forbes.com/advisor/health-insurance/how-much-does-it-cost-to-have-a-baby/ (last updated January 3, 2024).

[12] Congressional Research Service, *Who Pays for Long-Term Services and Supports?* https://crsreports.congress.gov/product/pdf/IF/IF10343 (last updated September 19, 2023).

market was born.[13] From our nation's inception methods of satisfying the costs of healthcare services have evolved from a simple, direct payment between patient and provider to an intricate web supporting today's infrastructure that is responsible for moving over $3 trillion dollars between patients and providers year-over-year.[14] Much of this spending over the past half century derives from Medicare, Medicaid, and employer-sponsored health insurance plans, none of which provide direct healthcare services to its enrollees but collectively satisfy some or all of the costs of healthcare to the overwhelming majority of Americans.[15]

To support a growing population reliant on immediately available healthcare that is as administratively efficient as possible and available to as many as possible; keep costs affordable while embracing the rapid emergence of medical breakthroughs and the provision of holistic care; and, ensure credentialed healthcare providers remain in the U.S. healthcare system; Medicare, Medicaid, and the myriad private health insurance companies have all gravitated toward "managed care" to help buoy this delicate healthcare ecosystem. A managed care model, as will be further defined below, is simply a healthcare delivery system that links payment for covered healthcare services from the insurer to the providers of those services often through the use of a third-party entity and at an agreed-upon rate per enrollee.[16] Although managed care has been a viable solution (albeit with various setbacks) for more than a century it is now the predominant healthcare delivery system in the nation. In fact, most insured Americans receive healthcare coverage through some form of managed care.[17] While originating in the private sector, both Medicare and Medicaid have embraced the perceived efficiencies of managed care and have incorporated its use throughout both programs. The remaining focus of this presentation, though, will be on Medicaid's application of managed care.

Although most states have long used managed care models as a Medicaid delivery method for one or more Medicaid covered services, not every state employs this approach

---

[13] Peter D. Fox, *A History of Managed Health Care and Health Insurance in the United States,* https://samples.jbpub.com/9781284043259/Chapter1.pdf (last updated September 3, 2015).
[14] Centers for Medicare and Medicaid Services, *National Health Expenditure Fact Sheet,* https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet (last updated September 10, 2024).
[15] *Id*.
[16] Fox, *supra* n. 13.
[17] L.E. Block, *Evolution, Growth, and Status of Managed Care in the United States,* https://pubmed.ncbi.nlm.nih.gov/9553445/#:~:text=Currently%2C%20three%2Dquarters%20of%20Americans,Americans%20enrolled%20in%20such%20plans (last accessed September 2024).

specifically for the delivery of long-term services or supports.[18] The increasing number of states that are providing Medicaid-funded LTSS through managed care systems, however, are doing so, in part, to control costs while increasing utilization rates among the population of current or prospective Medicaid enrollees. But is this model working?

A brief history of managed care as a Medicaid delivery system will be explored below, followed by a discussion of the impact that the competing goals of cost containment and increased health services utilization has on the long-term viability of the managed care model. This topic will also provide a synopsis of the various states' approach to the provision of LTSS through this delivery system, and then conclude with a survey of the challenges and successes that states and Medicaid enrollees may experience as managed care continues to evolve.

II. The Historical Development of Managed Care

Prior to the 20th century, healthcare services in the United States were primarily paid directly by the patient to the provider in the form of cash, goods, or labor (the original fee-for-service model).[19] Although there is documented evidence that as early as the colonial period well-regarded physicians would contract with wealthy clients to provide on-demand medicine at a fixed annual rate,[20] such arrangements were a concierge service rather than an insurance product to hedge against financial disruption.[21] And while sporadic employer-sponsored health benefits began to emerge in the first half of the 19th century by the railroad, mining, and lumber industries treating sick or injured tradespeople and laborers through the provision of doctors and/or hospitals at or near the jobsite, it was not until much later that traditional health insurance took shape to include indemnity insurance in which another party (i.e., an insurer, employer, or government agency) was responsible for the payment of a patient's healthcare services.[22]

Historians frequently point to the wage control laws and favorable tax treatment of healthcare benefits of the WWII era as the powder keg that caused the stratospheric rise of

---

[18] Elizabeth Hinton, *10 Things to Know about Medicaid Managed Care,* https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ (last updated May 1, 2024).
[19] Erin Allen, *Paying the Doctor in 18th-Century Philadelphia,* https://blogs.loc.gov/loc/2016/04/paying-the-doctor-in-18th-century-philadelphia/ (last accessed September 2024).
[20] *Id.*
[21] Fox, *supra* n. 13.
[22] Fox, *supra* n. 13.

citizens with some form of healthcare coverage.[23] In a twenty-year period from 1940 to 1960 the number of individuals with healthcare coverage grew seven-fold from 20 million to an astounding 140 million.[24] In two decades, society went from an uninsured rate of over 90% to less than 10%.[25] Because of the high demand for maximum domestic factory output to support the war effort and the concurrent strained labor market due to the draft, wage controls were implemented limiting the amount of wages certain industries could pay its workers.[26] To remain competitive in the labor market and through the efforts of strong labor unions, employers would offer health insurance coverage as an in-kind benefit to offset those wage ceilings. Moreover, Congress exempted such employer-sponsored health coverage from federal income tax in 1954 thereby weaving the deep importance of healthcare coverage into the United States fabric.[27] By 1965, an already expansive insurance market grew markedly larger with the government's entrance via the passage of Medicare and Medicaid extending healthcare coverage to those not in the labor market due to age or ability, as well as those living in poverty.[28] Together these programs provided healthcare coverage to an additional 20 million Americans in just the first few years of inception.[29] Today, over 300 million Americans receive healthcare coverage from employer-sponsored health insurance, Medicare, and/or Medicaid collectively.[30]

During the last half of the 20th century as traditional indemnity insurance was growing in prevalence the primary delivery system between the patient, provider, and insurer was the "fee-for-service" model. Under this model, which still permeates throughout today's insurance market, physicians, hospitals, and other healthcare providers are paid by the insurer *per service* performed.[31] Critics of this model argue that it supports a volume-over-value proposition devoid of any coordinated care for the patient allowing providers to drive pricing to unsustainable

---

[23] Fox, *supra* n. 13.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] The author assumes the reader is familiar with the Medicare (42 U.S.C. § 1395 et seq.) and Medicaid (42 U.S.C. § 1396 et seq.) programs, the population of enrollees both programs cover, and the respective eligibility requirements.
[29] Fox, *supra* n. 13.
[30] Starkey, *supra* n. 10.
[31] Centers for Medicare and Medicaid Services, *Fee for Service Definition,* https://www.healthcare.gov/glossary/fee-for-service/#:~:text=A%20method%20in%20which%20doctors,include%20tests%20and%20office%20visits (last accessed September 2024).

rates.[32] Because insurers and providers operate independent of each other without incentivization under a fee-for-service approach, critics posit that consumer costs have ballooned and an "unrestrained delivery of services" have led to out-of-control insurance premiums and reduced health outcomes.[33]

Regardless of this criticism's validity, it was clear to President Nixon and Congress that an alternative healthcare delivery method should be explored to confront the soaring prices of (and spending on) healthcare services and the resulting inflationary pressures that both were having on the overall economy. By the early 1970s, most healthcare services were paid for by a third party rather than the patient directly, i.e., an employer-sponsored health plan, Medicare, and/or Medicaid. This new third-party payer system primarily delivered via fee-for-service effectively ended the payment relationship between the patient and provider, which had the net effect of increasing both price and utilization.[34] While the uninsured rate experienced a dramatic reduction by 45% in the 1960s, healthcare-related spending as a percentage of the GDP rose by 3 points during this same decade with healthcare costs outpacing the economy of the day.[35]

Many viewed managed care as a viable solution to a disjointed fee-for-service delivery approach which could concurrently control costs and expand the provision of coordinated, holistic medical care. As was loosely defined above, managed care is a healthcare delivery system that 1) integrates the patient, provider, and insurer; 2) designs cost control methods to, among other purposes, manage unnecessary healthcare utilization; 3) incentivizes competition among healthcare providers by rate and/or price-setting, and 4) provides administrative services and accountability.[36]

A Managed Care Organization (MCO) is the entity largely responsible for this integrated network. Depending on the geographic market and type of MCO, the consumer may have a range of restrictions placed upon their access to healthcare. Though there are a variety of hybrid MCOs, the three traditional MCOs under a managed care model are the 1) Health Maintenance Organization (HMO), 2) Preferred Provider Organization (PPO), and 3) a Point of Service (POS) plan. HMOs, often offered to enrollees for low or no deductibles, require enrollees to choose

---

[32] Naoki Ikegami, *Fee-for-Service Payment – an evil practice that must be stamped out?* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4322626/ (last accessed September 2024).
[33] Namburi, *supra* n. 9.
[34] Fox, *supra* n. 13.
[35] *Id.*
[36] Namburi, *supra* n. 9.

providers and hospitals that are *in-network*, greatly reducing covered services to enrollees seeking care of their choosing that may be found outside of the HMO's network of providers absent an emergency (restrictive).[37] With an HMO, an enrollee is required to have a primary care physician (PCP) who is responsible for coordinating care and referring an enrollee to specialists. Alternatively, PPOs are on the less restrictive side of the MCO spectrum where a PPO will enter into discounted pricing arrangements with select healthcare providers and allow the enrollee to see specialists without a PCP referral and (somewhat) free of a network/referral system.[38] Enrollees in a PPO will usually see higher deductibles as a result of the flexibility afforded to the enrollee under this plan.[39] POS plans are essentially a hybrid HMO/PPO that require an enrollee to select a PCP but allows for out-of-network services.[40] By 2022, 49% of employer-sponsored health insurance was offered through a PPO, followed by 12% enrolled in an HMO, and 9% in a POS. The remaining population was in a High Deductible Health Plan (HDHP) within an HMO or PPO.[41]

MCOs are supported in large part by a payment model in which the MCO builds a network of healthcare providers who offer comprehensive care to enrollees at a fixed-fee per member, per month (known as "capitation").[42] Put simply, if an enrollee's cost-of-care is less than the capitated rate over a sustained period, the MCO should be profitable. The risk of financial loss, as well as the benefit of any financial gain, is shifted to the MCO.[43] This risk/reward model, in turn, requires the MCO to be hyper-focused on the price of services by the provider, utilization of those services by the consumer, and quality of care received to improve patient outcomes.[44]

Although managed care did not formally enter the national health insurance conversation until the passage of the Health Maintenance Organization Act of 1973,[45] the managed care

---

[37] Namburi, *supra* n. 9.
[38] *Id*.
[39] University of Florida, *Choosing Your Health Insurance Plan,* https://news.hr.ufl.edu/benefits/choosing-your-health-insurance-plan-hmo-vs-ppo-vs-hdhp/ (last accessed September 2024).
[40] Namburi, *supra* n. 9.
[41] *Id*.
[42] Leona Rajaee, *What is Capitation in Healthcare?,* https://www.elationhealth.com/resources/independent-primary-care-practices-blog-elation-health-ehr/capitation (last updated April 10, 2024).
[43] *Id*.
[44] *Id*.
[45] *See* U.S. Gov. Accountability Office, *Implementation of the Health Maintenance Organization Act of 1973,* https://www.gao.gov/products/105122 (last accessed September 2024).

concept is credited for some of the first health insurance coverage offerings of the early 20th century with the advent of both the HMO and capitation concepts discussed above. [46] By way of example, in 1910 a clinic in Tacoma, Washington began offering mill owners and their employees' access to medical services for $.50 per month, effectively providing the consumer with a fixed cost and offering the clinic a revenue pipeline. [47] Not long after, by the late 1920s Blue Cross plans emerged when teachers in Texas were able to prepay for inpatient hospital care at Baylor Hospital (known as the "Baylor Plan"), which quickly expanded to other hospital associations and employers.[48] And then its twin, Blue Shield, entered a decade later when companies offered injured employees outpatient medical care offered by healthcare providers that the companies would contract with at a negotiated monthly fee, which would then be paid to the provider by a third-party.[49] Now, BlueCross and BlueShield – a longstanding provider of managed care plans – offers healthcare coverage to 1 in 3 Americans and has a network of almost 2 million healthcare providers and hospitals nationwide.[50]

As the indemnity insurance market continued to develop and expand in the latter half of the 20th century, along with both the fee-for-service and managed care delivery systems underlying this market, healthcare-related inflation grew rampant causing Congress to embrace managed care more fully through the passage of the HMO Act of 1973.[51] The third-party payer system comprised of the triad – Medicare, Medicaid, and employer-sponsored health insurance - was viewed to have further enabled that which most found off-putting with fee-for-service, which is inflated pricing by providers. By leveraging a risk-shifting model focused on capitation and coordinated care organized by a MCO that has *insight* into the patient and *oversight* of the provider, it was presumed that reduced costs to the insured, employers, and state and federal government alike would follow. The HMO Act of 1973 bolstered managed care by 1) offering grants and loans to support the expansion of HMOs; 2) preempt contradictory state law that would impede an HMO; and most importantly 3) requiring employers with more than 25

---

[46] Fox, *supra* n. 13.
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] BlueCross BlueShield, *The Blue Cross and Blue Shield System,* https://www.bcbs.com/about-us/blue-cross-blue-shield-system (last accessed September 2024).
[51] Fox, *supra* n. 13.

employees who offered healthcare coverage to provide at least one federally qualified HMO choice.[52]

The Employee Retirement Income Security Act (ERISA) of 1974 (protecting MCOs from malpractice), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (shifting Medicare hospital reimbursement from fee-for-service to a "prospective payment system" and creating the precursor to Part C), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)(extending temporary healthcare coverage during unemployment), and the Affordable Care Act (ACA)(extending Medicaid enrollment, increasing the age of a dependent entitled to coverage, and requiring coverage for pre-existing conditions) all had meaningful, substantive impacts to the development of managed care well into the 21st century.[53]

Managed care grew steadily from the HMO Act's enactment until the late 1990s when there was a backlash toward this model insofar as this was the only part of the healthcare system that would micromanage a patient's care and even deny coverage in the guise of case management as will be further discussed.[54] Nonetheless, this backlash eventually subsided and managed care returned to the forefront now covering 160 million Americans and is the primary delivery system for the 80 million Americans receiving Medicaid – except for LTSS covered services which remains fragmented.[55]

III. The Intersection of Medicaid and Managed Care

Grabbing the baton from Presidents Harry Truman and John Kennedy's efforts to extend healthcare coverage in the United States, in particular to older and low-income Americans, President Lyndon Johnson is credited for achieving some of the most sweeping healthcare-related legislation in the nation's history with the establishment of Medicare and Medicaid in 1965.[56] Although the political support, purpose, financing, eligibility, and healthcare coverage

---

[52] GAO, *supra* n. 45.
[53] Namburi, *supra* n. 9.
[54] *Id.*
[55] Centers for Medicare and Medicaid Services, *May 2024 Medicaid & CHIP Enrollment Data Highlights,* https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=80%2C855%2C947%20individuals%20were%20enrolled%20in,individuals%20were%20enrolled%20in%20CHIP (last accessed September 2024).
[56] National Archives, *Milestone Documents: Medicare and Medicaid Act (1965),* https://www.archives.gov/milestone-documents/medicare-and-medicaid-act#:~:text=On%20July%2030%2C%201965%2C%20President,for%20people%20with%20limited%20income. (last updated February 8, 2022).

for both programs are separate and distinct, both programs share a similarity inasmuch as each are undergirded by the fee-for-service and managed care delivery systems.

Managed care has been coupled with Medicare throughout Medicare's history. Original Medicare, comprised of Part A (Hospital Insurance) and Part B (Medical Insurance), is strikingly similar to the early Blue Cross and Blue Shield concepts which was attractive to members of Congress during this time and assisted in securing the votes necessary for the program's enactment. Furthermore, Medicare-recognized *HMO-type* plans were authorized for reimbursement at Medicare's inception eight years before HMOs were formally recognized in federal legislation.[57] With the 1972 amendments to the Social Security Act, Medicare managed care offered through HMO enrollment was introduced into the program, and the risk-based private plans associated with Medicare Part C (known as "Medicare Advantage") followed with the Tax Equity and Fiscal Responsibility Act of 1982 as enhanced by the Balanced Budget Act of 1997.[58] However, the effectiveness and usage rates of Medicare managed care has ebbed and flowed driven by vacillating legislation, fluctuating premiums, consumer-opposed cost control exercises, changing enrollee demographics (think Baby Boomers), and ever-changing provider payment methodologies.[59] Nonetheless, as of 2023 almost one-half of Medicare's 64 million recipients were enrolled in Medicare Part C – Medicare's primary managed care model. The remainder of Medicare's relationship with managed care is beyond the scope of this presentation and should be viewed separately from Medicaid's embrace of this delivery system.

Medicaid's foray into managed care and what led to managed care as the preferred delivery method among states' Medicaid programs took a more linear path likely resulting from the respective states mandated cost-share to fund the program that does not entirely exist within the Medicare framework.[60] Also, Medicaid, which offers a suite of healthcare coverage to low-income individuals, children, pregnant women, older Americans and those with special needs or disabilities, is a very unique healthcare structure serving a particular demographic that is different from the pools of plan participants found in employer-sponsored coverage and

---

[57] Thomas Mcguire, *An Economic History of Medicare Part C,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/ (last accessed September 2024).
[58] *Id.*
[59] *Id.*
[60] Fox, *supra* n. 13.

Medicare.[61] And assuming a state remains consistent with federal law and its approved state Medicaid plan, states have significant agency in the administration of its respective Medicaid program (including the services covered and excluded) causing variability among states. For these and other reasons one should expect that Medicaid managed care follows a separate trajectory than the managed care models of the other two members of the triad. Nevertheless, by employing managed care as a Medicaid delivery system, states generally experience "budget predictability" and reduced administrative responsibilities while the enrollee receives coordinated care, which is not often found when states assume these functions under a fee-for-service approach.[62] With the stated goals of reducing Medicaid program costs to the state and federal government while concurrently increasing patient utilization and improved health outcomes,[63] Medicaid managed care is now at the forefront of most states' Medicaid programs.

Eleven years after Medicaid was signed into law and only three years following the passage of the HMO Act of 1973, Congress amended the HMO Act to permit states that offered Medicaid to contract with federally qualified HMOs to deliver Medicaid covered services so long as the respective HMO had no more than 50% of its enrollees enrolled in either Medicare or Medicaid.[64] This cap was increased to 75% with the Omnibus Budget Reconciliation Act of 1981 and then eliminated in its entirety with the Balanced Budget Act of 1997, at which point managed care grew exponentially within the Medicaid framework.[65] California first explored Medicaid managed care as early as 1971 at the behest of Governor Ronald Reagan to reduce Medicaid spending, by the 1980s Arizona sought to offer Medicaid managed care as the only Medicaid delivery system available in the state, and now 40 years later, the majority of states leverage a Medicaid managed care model to provide covered services to nearly two-thirds of Medicaid enrollees nationwide.[66]

---

[61] *See* Centers for Medicare and Medicaid, *Medicaid,* https://www.medicaid.gov/medicaid/index.html (last accessed September 2024).
[62] Hannah Maniates, *Why did they do it that way? Understanding Managed Care,* https://medicaiddirectors.org/resource/understanding-managed-care/ (last updated January 22, 2024).
[63] *See* Centers for Medicare and Medicaid, *Managed Care,* https://www.medicaid.gov/medicaid/managed-care/index.html (last accessed September 2024).
[64] Maniates, *supra* n. 62.
[65] *Id.*
[66] *See* Kaiser Family Foundation, *Medicaid Managed Care Tracker,* https://www.kff.org/statedata/collection/medicaid-managed-care-tracker/#about-this-collection (last accessed September 2024).

Federal regulations recognize four MCO entities under the Medicaid managed care model – Managed Care Organizations (MCO), Primary Care Case Management (PCCM), Prepaid Inpatient Health Plan (PIHP), and the Prepaid Ambulatory Health Plan (PAHP).[67] The MCO offering provides the Medicaid enrollee a comprehensive benefits package (i.e., primary, acute, and specialty care) with payment based on capitation.[68] With a capitated Medicaid managed care program the state will pay an MCO a monthly rate per Medicaid enrollee for the MCO to manage a range of services, including, but not limited to, 1) establishing provider networks; 2) satisfying payment to providers for Medicaid-covered services; 3) implementing utilization management practices and other program administration responsibilities; and 4) providing care coordination for enrollees.[69] This model shifts the risks associated with the cost to administer Medicaid from the state to the MCO thus making this the preferred managed care program among the states. Alternatively, PCCMs provide for primary care case managers who contract with the state Medicaid agency to provide case management on a fee-for-service basis in addition to a monthly case management fee; whereas, PIHPs only offer limited benefits for inpatient hospital and other institutional settings at either a capitated rate or fee-for-service, and conversely, PAHP plans offer limited coverage that excludes inpatient hospital and other institutional settings.[70] Of the 90 million Medicaid enrollees in 2021, 77 million where enrolled in any one (or more) of the MCO options outlined above with a staggering 67 million enrolled in a comprehensive, risk-based (capitated) MCO.[71]

State Medicaid agencies are authorized to deliver Medicaid benefits to eligible residents within a managed care framework under several federal enabling authorities. The three primary authorities, however, are the State Plan Authority found in 42 U.S.C. § 1932(a) and the two

---

[67] 42 CFR § 438 et seq.
[68] Centers for Medicare and Medicaid Services, *Managed Care Entities,* https://www.medicaid.gov/medicaid/managed-care/managed-care-entities/index.html (last accessed September 2024).
[69] *Id.*
[70] *Id.*
[71] *See* Centers for Medicare and Medicaid Services, *Managed Care Enrollment Summary,* https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369/data?conditions[0][property]=year&conditions[0][value]=2021&conditions[0][operator]=%3D (last updated July 21, 2023).

Waiver Authorities found in 42 U.S.C. § 1915(a)-(b) and 42 U.S.C. § 1115.[72] These statutes effectively permit a state to deviate from otherwise required federal Medicaid law to implement a managed care delivery system which grants states broad discretion to 1) design a managed care delivery system targeting certain geographic areas of a state rather than offering a statewide plan; 2) provide different benefits to different people enrolled within the managed care system; and 3) only afford Medicaid enrollees a Medicaid managed care option.[73] A state's process to design, implement, and execute a Medicaid managed care delivery system will vary depending on the respective authority(ies) from which the state sought approval. Notwithstanding these authorities, all states are required to comply with federal law applicable to managed care.[74] This includes requiring state oversight of MCOs, notice obligations, appeals and grievance processes, provider network governance, access to providers, and enrollment support.[75] Because of the sheer monetary value of a managed care contract between a state and MCO, there are voluminous procedural requirements surrounding the procurement process, capitation/rate setting, utilization management, and monitoring and enforcement actions.[76] It is in the value of these contracts and resulting financial incentives that states are able to require MCOs to focus on increased access to quality healthcare services.

However, the flexibility offered to states in the Medicaid managed care space is a leading contributor of the variation among state Medicaid programs as it relates to the type and volume of Medicaid managed care plans, the number of enrollees, and the healthcare services covered (or excluded).[77] This is readily apparent when a Medicaid enrollee attempts to move out-of-state and then reestablish coverage in their new state. Despite the negative consequences that may arise from these disparities the fiscal savings and program administration support experienced by a state utilizing a Medicaid managed care model will continue to make this model the preeminent delivery system for Medicaid benefits nationally. In particular, the risk-based, capitated MCO plan is the most attractive form of Medicaid managed care as evidenced by the 41 states who

---

[72] *See* Centers for Medicare and Medicaid Services, *Managed Care Authorities,* https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html (last accessed September 2024).
[73] CMS, *supra* n. 72.
[74] Maniates, *supra* n. 62.
[75] CMS, *supra* n. 72.
[76] Maniates, *supra* n. 62.
[77] *Id.*

employ this particular delivery system.[78] In fact, payments to MCOs comprised over 50% of state and federal Medicaid spending compared to 39% of spending delivered through a fee-for-service structure.[79]

While managed care is now firmly rooted in the delivery of Medicaid benefits nationally, ever-changing state and federal political landscapes, market pressures, and a complex regulatory framework dictate that Medicaid managed care will continue to evolve.[80] Where states were previously using the flexibility afforded by managed care as a sword to exclude coverage for a number of healthcare services, like LTSS, mental or behavioral health, and prescription drug coverage, the tide is changing and such programs are now being scoped into MCO contracts.[81] This is particularly true for LTSS benefits where spending grew from $6 billion in 2008 to $47 billion in 2019. Unfortunately, though, enrollment in MCOs for adults over 65 or those with a disability who require LTSS continues to trail the enrollment figures for children and adults receiving other Medicaid covered services.[82] For instance, the penetration rate for adults over 65 or those with a disability remains at or below 50% in a majority of the 41 states offering Medicaid managed care.

IV. Delivery of LTSS through a Medicaid Managed Care Model

As outlined in the Introduction, the advent and advancement of modern medicine and other therapies have allowed Americans to live longer, as well as live more independently with a disability or special need.[83] But these breakthroughs come with challenges, especially related to receiving and paying for the long-term services and supports necessary to support one's aging process. These challenges become transparent when coupled with the "gray tsunami" of seventy-three million baby boomers graduating into retirement who will soon comprise 20% of the U.S. population thereby placing increased demand on the LTSS infrastructure. Moreover, almost 30% of adults in the United States reported having a disabling or chronic condition in 2022; of those

---

[78] Elizabeth Hinton, *10 Things to Know About Medicaid Managed Care,* https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ (last updated May 1, 2024).
[79] Hinton, *supra* n. 78
[80] Maniates, *supra* n. 62.
[81] Hinton, *supra* n. 78.
[82] *Id.*
[83] Erica Reaves, *Medicaid and Long-term Services and Supports: A Primer,* https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/ (last accessed September 2024).

ages 18 to 44 within this population, 1 in 4 often did not have access to a healthcare provider or annual check-up leading to an unmet healthcare need.[84] Added to this population are the 70% of adults who will live to age 65 and develop a need for assistance with one or more ADLs at home or in an institutional setting but may not have adequate finances to satisfy the attendant costs for a sustained period.[85] For these reasons, both the access to and affordability of LTSS-related healthcare services will be a growing topic of concern over the next several decades.

Because Medicare only offers limited coverage for LTSS, if at all, and there are not often viable commercial or employer-related insurance products readily available to this segment of society, Medicaid has become the primary payer of long-term care in the United States.[86] As of 2020, over 30% of the $597 billion in Medicaid spending was related to long-term care services even though the number of Medicaid enrollees receiving LTSS coverage was disproportionately small compared to the overall population of Medicaid recipients.[87] This fiscal disparity, along with the accelerated demand for complex healthcare and increased spending on long-term care within the Medicaid program, has caused states and the federal government to increasingly look toward creative solutions to deliver holistic long-term care services in a cost-efficient way, and once again, managed care is under consideration as a viable solution.[88]

People commonly conflate long-term care with institutional care provided in a skilled care facility. While there are over 1.6 million licensed nursing home beds in the United States,[89] LTSS are much more expansive than simply the provision of institutional care. In order to "facilitate optimal functioning" to the millions of Americans requiring long-term care, LTSS offers a range of healthcare and social services in the person's home, community, or facility, to

---

[84] Centers for Disease Control, *Disability and Health Promotion,* https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html (last updated July 2024).
[85] Richard Johnson, *What is the Lifetime Risk of Needing and Receiving Long-term Services and Supports?* https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0 (last updated April 3, 2019).
[86] Reaves, *supra* n. 83.
[87] Centers for Medicare and Medicaid Services, *Long Term Services and Supports,* https://www.medicaid.gov/medicaid/long-term-services-supports/index.html (last accessed September 2024).
[88] Medicaid and CHIP Payment and Access Commission, *Managed Long-term Services and Supports,* https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/ (last updated March 22, 2022).
[89] Centers for Disease Control, *Nursing Home Care,* https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (last updated November 5, 2023).

assist a person with limitations arising from a physical or mental condition or disability.[90] Such services may include skilled care, day programs, home health aides, personal care services, transportation, supported employment, caregiver support, and much more.[91] Medicaid offers broad coverage of LTSS, but this coverage and the underlying delivery method is inconsistent among the states.[92]

Historically, there has been a bias in the Medicaid program toward prioritizing institutional level-of-care by way of a fee-for-service model insofar as states are mandated to provide such coverage whereas home and community-based LTSS benefits are optional.[93] This bias has led to paradoxically disproportionate Medicaid expenditures allocated to the highest level of institutional care and a lack of care coordination for a population of Medicaid enrollees with incredibly complex health and social needs that could likely be met in the person's preferred residential setting.[94] Over time, however, there has been a recognition that institutional level-of-care is expensive, the traditional fee-for-service delivery system may not lead to a positive health outcome absent coordinated care, and most people prefer to remain in the residential setting of their choosing with proper supports to be able to do so. Medicaid-managed LTSS is designed to address these concerns.

Medicaid-managed LTSS is the delivery of the above-referenced services through a risk-based capitated managed care program where a state Medicaid agency contracts with an MCO to deliver LTSS benefits to eligible persons.[95] The eligible beneficiaries of this healthcare coverage tend to be individuals over age 65 or those ages 18 to 65 with a physical disability, although some states are starting to expand coverage to those with intellectual or developmental disabilities.[96] A case manager is often employed given the range of needs that these beneficiaries may encounter.[97] By utilizing a Medicaid managed LTSS model, care coordination, access to

---

[90] Nga Thach, *An Overview of Long-term Services and Supports and Medicaid: Final Report* https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0 (last accessed September 2024).
[91] Reaves, *supra* n. 83.
[92] Thach, *supra* n. 90.
[93] Reaves, *supra* n. 83.
[94] MACPAC, *supra* n. 88.
[95] *Id.*
[96] Elizabeth Lewis, *The Growth of Managed Long-term Services and Supports Programs: 2017 Update,* https://www.medicaid.gov/medicaid/downloads/mltssp-inventory-update-2017.pdf (last accessed September 2024).
[97] MACPAC, *supra* n. 88.

home and community-based services, and improved health outcomes may be expanded for this vulnerable population while also allowing the state to achieve cost-savings, enhanced program administration efficiencies, and a competitive market with increased plan offerings.[98]

With approval of the Centers for Medicare and Medicaid Services, states may develop a managed LTSS program as part of its Medicaid plan by using one or more of the three federal authorities outlined above.[99] Currently, 46% of managed LTSS programs were authorized under § 11115(a) Demonstration Waivers, 27% through §1915(b) Waivers, 15% by §1915(a) Waivers, and the remaining 12% through amendment to the states' respective state Medicaid plan.[100] Depending on the federal enabling statute, states have the ability to require mandatory enrollment in a managed LTSS plan as well as test new programs, services, and covered populations.[101] In a majority of the states with managed LTSS plans, both older adults and those with a mental or physical disability are covered with the remaining states offering coverage to only one group (either aged or disabled).[102] As of 2017, there were over 20 programs designed for enrollees with intellectual or developmental disabilities.[103] Regarding program exclusions, Arizona, Kansas and Wisconsin are currently the only states with managed LTSS programs in which all Medicaid-covered services are provided for within the MCO capitation rate, whereas the remaining states will carve out benefits from the capitation rate such as institutional care, home and community-based services, behavioral health, prescription drugs, and others.[104]

Even though Arizona was a pioneer that sought to leverage managed care in the delivery of LTSS in the early 1980s, much of this growth has occurred in recent years.[105] There are currently twenty-four states operating over forty-one managed LTSS programs, which is a three-fold increase from 2008.[106] This has caused both the enrollment in managed LTSS programs and the number of available managed LTSS plans to double from 800,000 to 1.8 million in the five-

---

[98] Reaves, *supra* n. 83.
[99] Centers for Medicare and Medicaid Services, *Managed Long-term Services and Supports, https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html (last accessed September 2024).*
[100] Lewis, *supra* 96 at pg. 11.
[101] Lewis, *supra* 96 at pg. 14.
[102] *Id.*
[103] Lewis, *supra* 96 at pg. 15.
[104] Lewis, *supra* 96 at pg. 19.
[105] Reaves, *supra* n. 83.
[106] MACPAC, *supra* n. 88.

year period from 2012 to 2017.[107] This delivery approach is similar to other Medicaid managed care products; however, the health needs of the enrollees receiving managed LTSS benefits are incredibly diverse which adds a layer of complexity as it relates to care coordination (utilization) and rate setting (capitation).[108] There are a variety of managed LTSS models offered by states ranging from the delivery of only LTSS covered services to comprehensive and fully-integrated LTSS programs that cover all Medicaid (and Medicare) services for the enrollee.[109] States with Medicaid managed LTSS may choose to target different participants with separate LTSS plans, such as those dual eligible for Medicare and Medicaid or individuals with intellectual or developmental disabilities, which why the number of available managed LTSS plans nationwide exceed the number of states offering managed LTSS coverage.[110]

Although there is a measurable movement toward states developing managed LTSS programs within their existing Medicaid managed care framework, Medicaid managed LTSS remains fragmented nationally. While there are several states considering the development of a managed LTSS program, Washington state retired its only managed LTSS plan.[111] In addition, given the different paths a state may follow driven by the respective federal enabling statute authorizing its managed LTSS program, there remains substantial variability among the managed LTSS programs throughout the country which is likely to be exacerbated as more states continue to implement managed LTSS. By way of example, the Florida Statewide Medicaid Managed Long-Term Care Plan was implemented in 2013 serving both older Floridians and those with physical disabilities.[112] Authorized under the § 1915(b) and § 1915(c) Waiver Authorities, over 93,000 Floridians are enrolled in a program that has the stated purpose of increasing the number of enrollees receiving care in the home or community rather than in an institutional setting while also limiting preventable hospitalizations and re-hospitalizations.[113] Florida's managed LTSS plan specifically excludes behavioral health, prescriptions, inpatient hospitalizations, and certain benefits for those with intellectual or developmental disabilities.[114] Conversely, the Kansas

---

[107] Lewis, *supra* 96.
[108] MACPAC, *supra* n. 88.
[109] Lewis, *supra* 96 at pg. 5.
[110] Lewis, *supra* 96 at pg. 19.
[111] Lewis, *supra* 96 at pg. 25.
[112] *Id*.
[113] *Id*.
[114] Lewis, *supra* 96 at pg. 34.

KanCare MLTSS Plan was established in the very same year under the § 1115(a) Waiver Authority, and its 33,000+ LTSS enrollee population is much more expansive (older adults, adults with disabilities, adults with intellectual or developmental disabilities, and children with disabilities) and does not carve out coverage from its capitation rate.[115]

As more states continue to adopt a Medicaid managed LTSS model it will be imperative that CMS play a central role in measuring and monitoring program and healthcare outcomes across the states, as well as develop a comprehensive and standardized framework for states to follow as it relates to program eligibility, access, and funding.[116] States will also play a key role in the expansion of LTSS benefits and should continue to explore innovative solutions through a managed LTSS system to offer comprehensive coverage with the goals of further reducing the reliance on institutional care and the resulting disproportionate Medicaid expenditures on such care.

V. Past is Prologue - The Future of Managed Care

Does managed care work for the triad? It depends, but managed care is the preferred healthcare delivery method driving the U.S. healthcare system currently and was created, in part, to carry the extreme weight of the healthcare delivery chassis. To the extent managed care was designed to increase utilization of necessary healthcare services, equitably distribute the costs and risks among providers and patients, and operate at appropriate aggregate expenditure levels, the results are mixed.[117] Studies have shown that managed care has effectively improved healthcare access and quality, yet there is debate as to whether MCOs are best able to provide the extensive care coordination necessary to simultaneously achieve utilization and cost-containment.[118] Additionally, market participants, related tax laws, provider practices, and patient needs continue to change, and with these changes the expectations and incentives for

---

[115] Lewis, *supra* 96 at pg. 41.
[116] *See* Centers for Medicare and Medicaid Services, *Measures for Medicaid Managed Long-term Services and Supports Plans: FAQ,* https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss-measures-faq.pdf (last accessed September 2024).
[117] Stanley Wallack, *Managed Care: Practice, Pitfalls, and Potential,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195142/ (last accessed September 2024).
[118] Maniates, *supra* n. 62.

MCOs to achieve real cost containment has declined as evidenced by the continued rapid spending on healthcare as a percent of GDP.[119]

As the managed care market continued to evolve in the last two decades of the 20th century with the rise in consolidation of MCOs and healthcare systems, changing regulatory expectations, and the emergence of for-profit managed care entities, a focus on utilization management increased which led to significant consumer backlash.[120] Consumers, in particular those with employer-sponsored health coverage, felt seemingly "pushed" into managed care by employers and were not accustomed to the requirement of prior authorization by a PCP as a prerequisite to obtain specialty care.[121] Being told "no" for treatment of a family member or loved one was off putting to the general public who had not previously experienced this effect under a traditional insurance structure; yet, this type of utilization oversight was necessary for MCOs to handle the significant growth experienced in the managed care market during this time. And while this backlash subsided early into the 21st century, there is no guarantee that this will not be a recurring complaint in the years ahead.

As it relates to Medicaid managed care and the delivery of LTSS services, there is a clear growth among states to prioritize healthcare quality for the aging and disability communities in order to reduce the need for expensive institutional care. But Medicaid managed LTSS models are not immune from the same challenges confronting managed care globally. Although capitated managed care is the primary delivery of Medicaid services for 75% of Medicaid enrollees, less than half of the states offer LTSS through this system and those that do often have extensive wait lists for those services.[122] Developing competitive capitation rates and other incentives for MCOs to scope in LTSS services will be integral to the long-term viability of LTSS within Medicaid. This will be challenging, however, due to the limited number of market participants as only five publicly traded companies account for over one-half of all MCO enrollment thus making the negotiation process between the state and provider(s) that much more arduous.[123] Lastly, there will continue to be inconsistencies in the delivery of managed

---

[119] Alain Enthoven, *Why Managed Care has Failed to Contain Costs,* https://www.healthaffairs.org/doi/10.1377/hlthaff.12.3.27#:~:text=One%20explanation%20is%20that%20the,to%20cut%20cost%20and%20price (last accessed September 2024).
[120] Fox, *supra* n. 13 at pg. 15.
[121] Fox, *supra* n. 13 at pg. 16.
[122] Hinton, *supra* n. 78.
[123] *Id.*

LTSS coverage insofar as states operate their Medicaid programs independent of each other and are able to deviate from federal law using a plethora of state and federal law and regulation, as well as enjoy immense flexibility in monitoring MCOs and defining provider network adequacy standards.

Fortunately, the federal government has taken notice of both the risks associated with the fragmentation of Medicaid managed care as well as the benefits that a successful Medicaid managed care approach can have on state and federal funding and improved patient care.[124] To this end, CMS promulgated the *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule*[125] in 2024, which resulted from Executive Order 14070 directing agencies to seek out ways to expand the availability of affordable healthcare coverage. This rule was issued to 1) strengthen standards for timely access to routine primary care; 2) enhance the fiscal integrity for state directed payments; 3) better define "in lieu of services" to address health-related social concerns; and 4) implement a quality rating system for Medicaid managed care plans.[126] This Rule along with the federal government's continued efforts to condition federal spending on sound managed care practices, in addition to the re-balancing incentives between states and MCOs linking financial incentives to increased quality performance areas in MCO contracts (like LTSS delivery), will have a meaningful, long-term impact which cannot be overstated.[127]

It is fitting that the National Archives, which includes in its catalogue the original Medicare and Medicaid Act, at the entrance of its building has as an inscription Shakespeare's famous admonition that what is past may be indicative of what is next.[128] If managed care can efficiently deliver a plethora of Medicaid covered services to tens of millions of enrollees, long-

---

[124] *See* Centers for Medicare and Medicaid Services, *Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS – 2439 – F)*. https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule (last updated April 19, 2024).

[125] 89 Fed. Reg. 40542 (2024).

[126] CMS, *supra* n. 124.

[127] Sara Rosenbaum, *The Medicaid Managed Care Rule is a Blockbuster,* https://www.healthaffairs.org/content/forefront/medicaid-managed-care-rule-blockbuster (last updated May 13, 2024).

[128] Jessie Kratz, *A Prologue to Prologue,* https://www.archives.gov/publications/prologue/2017/winter/historian-winter-2017#:~:text=The%20title%20Prologue%20was%20appropriate,presses%20on%20June%206%2C%201969 (last accessed September 2024).

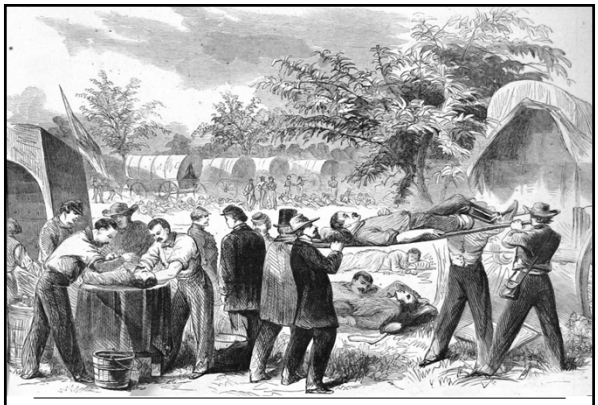
term services and supports should be included as a covered service under this model nationwide to best accommodate the unique needs of the next generation of Medicaid enrollees.

MANAGED CARE: *IS IT WORKING?*

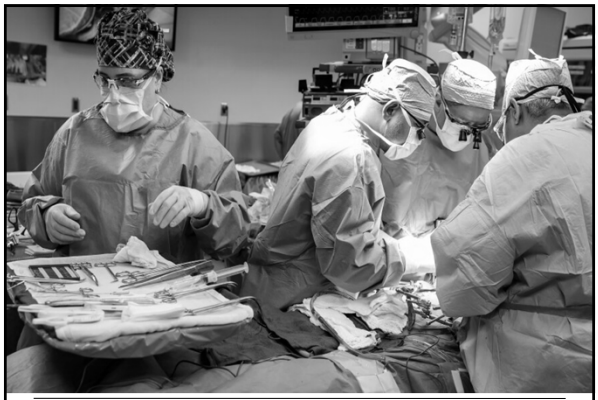
OCTOBER 16, 2024

Will Lucius, Chief Trust Officer
Raymond James Trust, N.A.

1



2

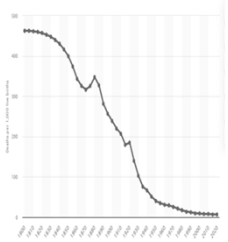


3

HISTORICAL TRENDS

LIFE EXPECTANCY

INFANT MORTALITY



4

'America's Grandmother' turns 115: Meet the oldest living person in the US, Elizabeth Francis

Saman Shafiq
USA TODAY

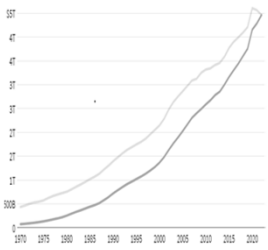
Published 11:35 a.m. ET July 25, 2024 | Updated 12:08 p.m. ET July 25, 2024

Elizabeth Francis on her 114th birthday. *Emmanuel Rodriguez / LongeviQuest*

5

HEALTHCARE SPENDING

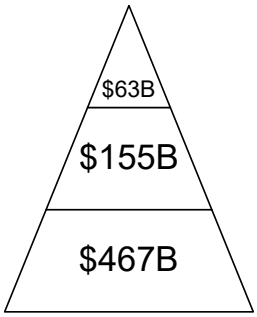
NATIONAL

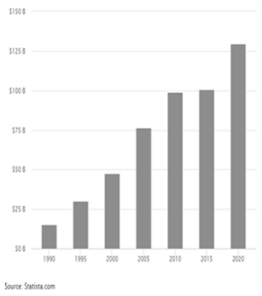


OUT-OF-POCKET

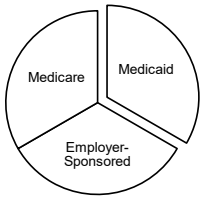
6

U.S. SPENDING ON LTC





7



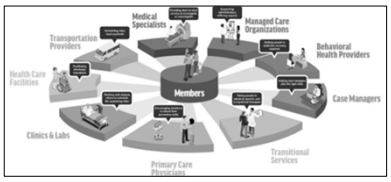
PAYING FOR HEALTHCARE IN THE UNITED STATES

Is Managed Care the answer?

8

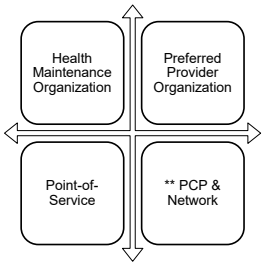
MANAGED CARE 101

- Healthcare Delivery System
- Financing + Service
- Third-Party Entity
- Capitated Rate



9

MANAGED CARE ORGANIZATIONS

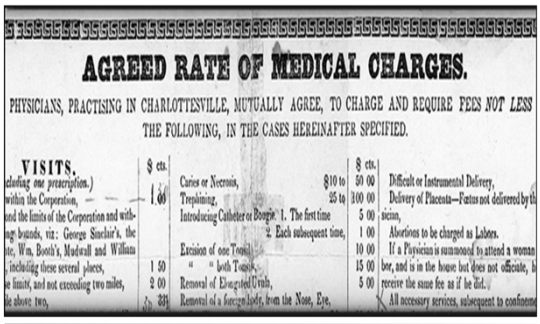


10

HISTORICAL DEVELOPMENT OF MANAGED CARE

11

FEE-FOR-SERVICE



AGREED RATE OF MEDICAL CHARGES.

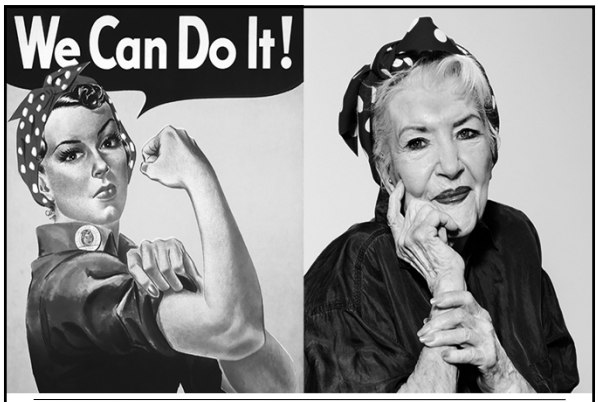
PHYSICIANS, PRACTISING IN CHARLOTTESVILLE, MUTUALLY AGREE, TO CHARGE AND REQUIRE FEES *NOT LESS* THE FOLLOWING, IN THE CASES HEREINAFTER SPECIFIED.

VISITS.	$ cts.
(including one prescription.)	1 00
within the Corporation,	1 00
and the limits of the Corporation and with-	
ing bounds, viz: George Sinclair's, the	
ite, Wm. Booth's, Madwall and William	
, including these several places,	1 50
e limits, and not exceeding two miles,	2 00
le above two,	33⅓

	$ cts.
Caries or Necrosis,	$10 to 50 00
Trephining,	25 to 100 00
Introducing Catheter or Bougie 1. The first time	5 00
2. Each subsequent time,	1 00
Excision of one Tonsil,	10 00
" " both Tonsils,	15 00
Removal of Elongated Uvula,	5 00
Removal of a foreign body, from the Nose, Eye,	

	$ cts.
Difficult or Instrumental Delivery,	
Delivery of Placenta—Parties not delivered by th	
sician,	
Abortions to be charged as Labors.	
If a Physician is summoned to attend a woman	
bor, and is in the house but does not officiate, h	
receive the same fee as if he did.	
All necessary services, subsequent to confineme	

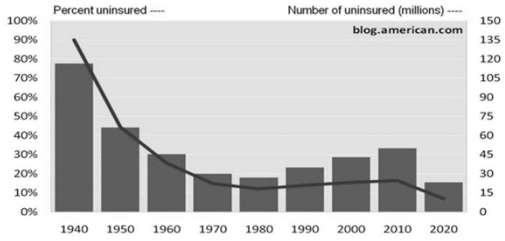
12



13

SECTION 106 (I.R.C.)

6.6 | The risk of being uninsured has declined by more than 80 percent between 1940 and 2010



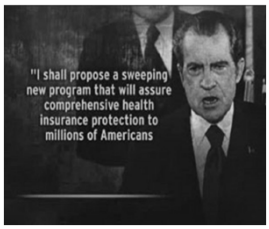
Note: Figures simulate the gross number of uninsured as if measured by today's Current Population Survey.

14

HMO ACT OF 1973

ACT FEATURES

- **Inflationary pressures and inefficiencies of FFS system**
- **Supported expansion of HMOs**
- **Preempted state law**
- **HMO choice in employer-sponsored coverage**



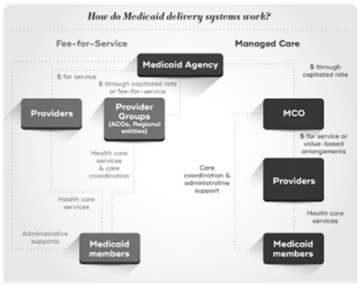
15

INTERSECTION OF MEDICAID & MANAGED CARE

16

MEDICAID MANAGED CARE

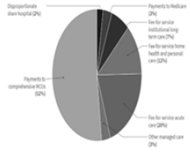
- HMO Act Amendments
- Budget predictability
- Cost containment
- Administrative efficiency
- Increased utilization
- Coordinated care
- Improved healthcare outcomes

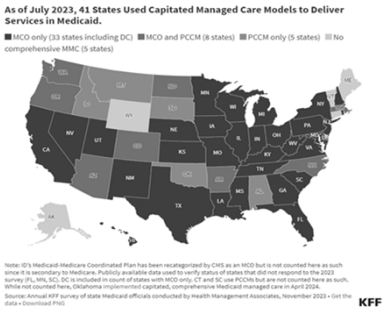


17

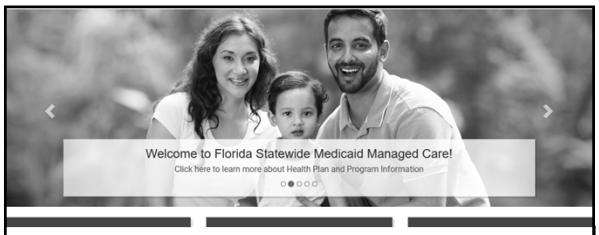
ENABLING AUTHORITIES

- 42 U.S.C. § 1932(a)
- 42 U.S.C. § 1915(a)
- 42 U.S.C. § 1915(b)
- 42 U.S.C. § 1115





18



DELIVERY OF LTSS BENEFITS IN A MEDICAID MANAGED CARE MODEL

Remains fragmented…

19

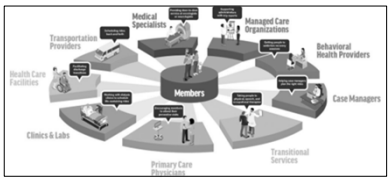
LONG-TERM SERVICES AND SUPPORTS

It is expensive.

20

MLTSS 101

- Risk-based, capitated program
- State MA Agency & MCO
- <65 + people with disabilities
- Enabling Authorities



21

MLTSS FUNDING

1.8 million

22

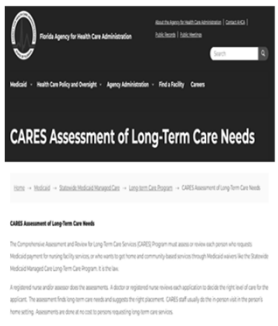
22

MLTSS CHALLENGES

State variation

Funding | I/DD

Network | Denials | Access



23

23

FUTURE OF MANAGED CARE – IS IT WORKING?

When Past is Prologue

24

MANAGED CARE BACKLASH

AS THE MARKETPLACE CHANGES, CONSUMERS ARE CAUGHT IN THE MIDDLE

By Stuart Auerbach
June 25, 1996 at 1:00 a.m. EDT

After undergoing breast cancer surgery, Kathleen Newell required another operation to strengthen her abdominal wall. Her Johns Hopkins University surgeons wanted the 59-year-old Columbia shoe saleswoman in the hospital a day early for preoperative medication. But Newell recalls that the gatekeeper physician at her health maintenance organization (HMO) overruled the surgeon's recommendations and told her to take the medicine at home.

25

FINAL RULE

- ***"MA and CHIP Managed Care Access, Finance and Quality Final Rule":***

1. **Strengthen standards for access to primary care**
2. **Enhanced fiscal integrity**
3. **"In lieu of services"**
4. **Quality rating system for MCOs**

<u>Still needed</u>

1) **Network quality monitoring**
2) **Comprehensive, standardized assessments**
3) **Increased funding**

HealthAffairs

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS: PAYMENT | MEDICAID | MANAGED CARE | TAXES | HEALTH CARE PROVIDERS | MEDICAID MANAGED CARE | COSTS AND SPENDING | QUALITY OF CARE | MEDICAL LOSS RATIO | WAIT TIMES

The Medicaid Managed Care Rule Is A Blockbuster

Sara Rosenbaum, Maria Casoni

MAY 13, 2024 10.1377/forefront.20240513.924164

26

AP ☰ WORLD U.S. ELECTION 2024 POLITICS SPORTS ENTERTAINMENT BUSINESS SCIENCE FACT CHECK ODDITIES BE WE

Vanderbilt beat Alabama Tropical Storm Milton Mideast wars Bronny James Keanu Reeves debut AP SU

U.S. NEWS

States offer services for disabled kids, then make their families wait 10 years for them

27

Will Lucius, J.D.
Chief Trust Officer

Raymond James Trust N.A.
T 727.567.7758 // F 727.567.7482
880 Carillon Parkway
St. Petersburg, FL 33716
will.lucius@raymondjames.com

QUESTIONS???

28


STETSON
LAW
Center for
Elder Justice
Access and Justice For All®