



## Considerations Associated with Selected Federal Authorities for Home and Community Based Services

HEALTHCARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.



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**PREPARED FOR:**

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## Overview

Through the development of its No Wrong Door (NWD) Three-Year Plan, Indiana has the opportunity to increase access to Medicaid funded home and community-based services (HCBS). Indiana currently provides HCBS under federal 1915 (c) authority and maintains a nursing home transition program through its Money Follows the Person (MFP) Demonstration Grant. The state also provides Long Term Services and Supports (LTSS) in institutional settings, and these services account for the majority of LTSS expenditures in the state.

The Lewin Group is a contractor supporting Indiana's No Wrong Door Three-Year Plan development efforts. The Indiana Family and Social Services Administration (FSSA), Division of Aging (DA) asked the Lewin Group to identify opportunities to promote rebalancing associated with state plan authorities 1915(i) and 1915(k). This report provides selected background information and describes key considerations associated with these authorities for older persons and people with disabilities. Key considerations include:

- ▶ Delinking institutional and community functional eligibility;
- ▶ Waiting lists and individual enrollment limits;
- ▶ Expanded financial eligibility;
- ▶ Targeting services to sub-groups;
- ▶ Nursing facility transition; and
- ▶ Managed LTSS (MLTSS).

The main HCBS program operated by the DA for older persons and people with disabilities is called the Aging and Disabled program (A&D) and operates under 1915 (c) authority. Therefore, we include some background on the 1915(c) requirements for comparison. We also provide suggestions to promote rebalancing and budget sustainability beyond the 1915(i and k) authority requirements.

This report includes a summary matrix highlighting requirements of each federal authority option to assist the DA in weighing the relative merits of pursuing any of the new or amended federal authorities. While additional mechanisms exist (e.g. PASRR reform and addressing nursing facility capacity and payment rates) to promote state rebalancing efforts, this analysis is limited to strategies that have direct implications for the federal authority of HCBS for older persons and people with disabilities.

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## Background

Many states are interested in receiving the six percent additional Federal Medical Assistance Percentage (FMAP) available for the Community First Choice 1915(k) state plan option that was created under the Affordable Care Act (ACA). Congress authorized the Community First Choice 1915(k) state plan option to allow states to extend coverage under their Medicaid state plan for attendant service and support programs. Under this option, states must offer attendant care services to all eligible individuals, cannot set waiting lists, and services must be participant-directed. States are also considering the opportunity to cover 1915(i) state plan HCBS established under the Deficit Reduction Act of 2005 and expanded under the ACA. This new option allows states to extend HCBS services to individuals who currently do not meet institutional level of care eligibility requirements. Unlike the other authorities discussed in this report, which allow participant direction, the 1915(k) authority requires participant direction. Due to this unique aspect, a summary of the 1915(k) requirements related to participant direction are discussed in this section.

In FY2013 Indiana spent \$2.078 billion on LTSS for older persons and people with physical disabilities, of which \$1.695 billion, or 82%, was provided in nursing facilities. Medicaid HCBS expenditures account for 18% of all LTSS spending for older persons and people with disabilities in Indiana.<sup>1</sup> This percentage is among the lowest in the nation. Indiana ranks 44th among all states in the percentage of LTSS spending for HCBS for older persons and people with disabilities.<sup>2</sup> As the state develops its' No Wrong Door Three-Year Plan, it is exploring developing, and/or re-designing, its existing HCBS authorities to rebalance the distribution of Medicaid LTSS options, increase access to HCBS, and ultimately lower costs to the state's Medicaid program. A summary of the role of ADRCs in rebalancing is discussed in this section.

### Participant Direction and the 1915(k) Option

Participant direction in HCBS refers to services that participants, or their representatives if applicable, have decision-making authority over and for which they take direct responsibility for managing. Participants are able to manage all aspects of service delivery and can include the assistance of a network of available supports, if desired.

Participant directed services include a person-centered planning process and a comprehensive assessment of functional needs and participant preferences that results in the development of participant-directed service plans and individualized budgets. Individual budgets include all the services chosen by the individual and approved by the program for which the individual and/or

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<sup>1</sup> Eiken, et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. June 30 2015. Data retrieved from Table AP at this link <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>

<sup>2</sup> Eiken, et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013. June 30 2015. Data retrieved from Table 15 at this link <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>

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authorized representative manages. As part of the individual budgeting requirements under 1915(k) authority, states are required to: (1) describe the methodology for calculating the dollar values of individual budgets based on reliable costs and service utilization; (2) define a process for making adjustments to the budget when changes in participants' person-centered service plans occur; and (3) define a procedure to evaluate participants' expenditures. In addition to offering participants control over their individual service budget, participants can also exercise employer authority over their service providers.

Participant direction programs must include Financial Management Services (FMS). A FMS provider assists individuals with exercising budget and employer authority for their participant-directed services. FMS includes support with the following:

- ▶ Understanding billing and documentation responsibilities;
- ▶ Performing payroll and employer-related duties;
- ▶ Purchasing approved goods and services;
- ▶ Tracking and monitoring individual budget expenditures; and
- ▶ Identifying expenditures that are over or under the approved individual budget.

## Leveraging ADRCs

Aging and Disability Resource Centers (ADRCs) play an integral role in state NWD System rebalancing efforts. ADRCs provide individuals with information about their LTSS options, including HCBS, provide person-centered counseling and decision support, and help connect individuals to desired services, if needed. This includes supporting individuals to utilize HCBS through public and private pay sources. In the context of Medicaid and Medicaid-funded HCBS, ADRCs can help individuals navigate the complicated and often overwhelming eligibility and application processes and identify and access providers of HCBS best suited to meet their needs. This often includes the selection of non-Medicaid covered services or other LTSS, such as assisted living and private pay in-home services: important service options for individuals who are not yet financially eligible for Medicaid services. Appropriate person centered counseling can help individuals stretch their financial resources and remain in their homes as long as possible. This important diversion function promotes rebalancing by preventing individuals from prematurely entering nursing facilities or assisting living facilities and exhausting their private resources. Nursing facility transition is discussed further in the Key Considerations section below.

Indiana ADRCs are independently operated by local Area Agencies on Aging (AAAs). Indiana seeks to unite the AAAs into a shared vision for a NWD system while building partnerships among one another and other agencies and organizations in order to support the diverse needs of the populations served by a NWD system including: older persons, persons with disabilities, persons with intellectual and developmental disabilities, and persons with mental health and substance use disorders. The inclusion of ADRCs and their expanded partners into the fabric of

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NWD system design has the potential to provide a solid foundation for long term partnerships and infrastructure enhancement as well as resource sharing and data tracking— important components of rebalancing efforts. While there is no specific or formal role for ADRCs in the consideration and development of HCBS authority options, the state could pursue opportunities to engage ADRC stakeholders in its rebalancing efforts through inclusion of ADRC leadership on stakeholder workgroups, soliciting feedback from ADRCs on early drafts of authority applications and during public commenting periods, and playing a role in ongoing quality improvement efforts down the road.



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## Key Considerations

As requested by the DA, this report presents opportunities and constraints associated with the 1915 (c), (i), and (k) federal HCBS authorities. To support Indiana’s on-going efforts to promote rebalancing of services for individuals supported by DA programs, this section outlines the following key considerations:

- ▶ Delinking institutional and community functional eligibility;
- ▶ Waiting lists and individual expenditure limits;
- ▶ Expanded financial eligibility;
- ▶ Targeting services to sub-groups;
- ▶ Nursing facility transition; and
- ▶ Managed LTSS (MLTSS).

### Delinking Institutional and Community Functional Eligibility

Indiana’s current nursing home level of care requires skilled medical needs or difficulties with three or more activities of daily living. Functional eligibility for the Indiana A&D waiver is based on this nursing home level of care because the program operates under the 1915(c) authority. Some states use different Medicaid authorities to set different levels of functional eligibility for LTSS for institutional and home and community based settings in order to divert individuals with lower acuity needs from higher cost, and less preferred institutional settings. Under the 1915(i) authority, states can set needs based criteria for HCBS eligibility standards that are not linked to the institutional level of care, allowing states to leverage HCBS services to prevent or delay institutionalization.<sup>3</sup> In essence, states are able to serve individuals who are considered “at risk” of institutionalization in less intensive settings and provide necessary services in the hopes of delaying, or diverting, individuals from more costly institutional services. Conversely, the 1915(k) authority requires a person to meet the state’s institutional level of care.

Indiana is currently piloting the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE 2.0) program with state only funding. This program serves individuals who need assistance with at least two activities of daily living and are not eligible for Medicaid. The findings from the pilot will allow the state to evaluate the options for delinking functional eligibility for institutional and HCBS for Medicaid recipients because it will provide information about the utilization of HCBS among individuals whose support needs are below the threshold for institutional care.

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<sup>3</sup> This is also permissible under 1115 authority.

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## **Waiting Lists and Individual Expenditure Limits**

Some states have waiting lists for HCBS 1915(c) waiver services as a result of enrollment limits. Enrollment limits and waiting lists present competing concerns between desires to meet the needs of more citizens while also operating within budgetary constraints. Individual expenditure limits are also allowed under all three authorities.

Operating under the 1915(c) waiver authority, Indiana's Aged and Disabled (A&D) program is subject to federal cost neutrality requirements. This means that the total cost of Medicaid services for A&D waiver recipients cannot exceed the amount that it would have cost to serve those individuals in a nursing facility or other institution. Based on Indiana state program data, the approximate cost of Medicaid services for individuals in the A&D program is \$3,400 PMPM (\$1,200 in waiver program costs and \$2,200 in other state plan costs) compared to \$4,500 in a nursing facility.

Currently there is no waiting list for the Indiana A&D waiver and no individual expenditure limit. As the baby boomer population continues to age and the state continues to promote various rebalancing initiatives, demand for waiver services will likely increase. Consequently, anticipating ways to control expenditures is an important consideration for evaluating federal authority options. The state might consider implementing a waiting list to address the potential growth in program utilization. It may also consider employing utilization management techniques, including, but not limited to, requiring prior authorization for services and linking authorization to objective cost-effective assessment criteria, and prioritization of individuals served based on risk of institutionalization.

However, given the high cost of non-waiver services for A&D program participants, there may be greater opportunity for savings with those services than with waiver enrollment or individual expenditure limits. For example, Indiana does not cover state plan personal care services, but does cover home health services. Typically HCBS care managers are encouraged to maximize state plan home health services to meet client needs prior to authorizing 1915 (c) waiver services. Prior authorization of home health services in Indiana is conducted independent of any care management oversight. The state might consider measures to ensure that authorization of state plan home health and 1915 (c) waiver services are not duplicated and that services are provided by the most cost effective providers.

## **Expanded Financial Eligibility**

Under certain Medicaid authorities, States have the flexibility to expand Medicaid eligibility for individuals at the nursing facility level of care to up to 300% of the Federal Poverty Level (FPL). As a result, individuals with the higher income receive Medicaid covered acute and primary services as well as HCBS due to their level of care. Financial eligibility varies across authorities.

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The 1915(c) and 1915(i) authorities allow for eligibility to be as high as 300% of FPL, while the 1915(k) option is limited to 150% of FPL.

The Indiana A&D program currently includes expanded eligibility up to 300% of FPL. Further analyses of Medicaid expenditures for A&D program participants at higher income levels, as well as those in the CHOICE 2.0 program, are advised to determine and fully assess the impacts of changes in expanded eligibility on the overall budget and service system capacity.

### **Targeting Services to Sub-Groups**

States have considerable flexibility in development of home and community based programs to serve the unique needs of individuals. Consequently, the number and type of Medicaid HCBS programs varies across states. The 1915(c) and 1915(i) authorities allow for targeting and allow states leeway in determining which populations are eligible for services. The 1915(k) option does not allow for any targeting and all services offered under this authority must be made available to all eligible individuals.

There is currently a waiting list for the 1915(c) waiver providing services to individuals with Traumatic Brain Injuries (TBI) in Indiana. There is also some concern that the ability to demonstrate 1915(c) waiver cost neutrality may become increasingly challenging. Analysis of this population may be warranted to determine if other federal authorities may be more cost-effective for the state. Further analysis of cost and utilization data for HCBS may also help to identify additional sub-populations (such as individuals with Alzheimer's or other dementias) that may be more cost-effective under other Medicaid authorities. Analysis of short and long-term nursing facility residents with relatively low acuity levels or whose nursing home stay is preceded by a hospitalization may suggest additional sub-groups to consider for targeting under 1915(i) authority.

### **Nursing Facility Transition**

Transitioning individuals receiving institutional LTSS back to the community is an important rebalancing effort. Many states, including Indiana, capture enhanced FMAP available through the Money Follows the Person (MFP) demonstration to cover the costs associated with these transitions. With the MFP demonstration coming to an end, states need to ensure that transition support and services are available within on-going HCBS programs.

Indiana is improving their Preadmission Screening and Resident Review (PASRR) processes and is planning to sustain transitions at the end of the MFP program. The A&D program includes transition services and case management. The state should review the current 1915(c) waiver to ensure that it includes pre-transition case management and transition services provided up to 180 days prior to the date the individual transitions into the community. Coverage for transition services up to 180 days prior to transition is also allowable under both the 1915(i) and 1915(k) authorities. Availability of affordable housing may become a barrier to transitions as more



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individuals who transition seek independent housing options over assisted living arrangements. DA is encouraged to coordinate with the state housing authority to address the housing needs of older people and persons with disabilities who transition from nursing facilities into the community.

### **Managed Long-Term Services and Supports**

More and more states are implementing managed long-term service and support programs to contain costs, improve quality, and allow greater flexibility to enrollees. Managed LTSS (MLTSS) programs could include services established under any of the 1915 authorities discussed in this report. Further analysis of Indiana's LTSS and other Medicaid expenditures for individuals at the nursing facility level of care are recommended to assess whether transitioning to MLTSS or adding LTSS to its existing managed care programs would prove more cost-effective.

**Table 1: Key HCBS Federal Authority Considerations for Indiana**

<b>Considerations</b>	<b>1915(c) HCBS</b>	<b>1915(i) State Plan HCBS Option</b>	<b>1915(k) Community First Choice</b>
De-linking functional eligibility	Not allowed; Institutional level of care required	Allowed	Not allowed; Institutional level of care required
Waiting Lists/Enrollment Limits	Allowed	Allowed	Not allowed
Individual Expenditure Limits	Allowed	Allowed	Allowed
Enhanced FMAP	n/a	n/a	Offers six percent enhanced FMAP
Increasing financial eligibility	Allowed up to 300% FPL	Allowed up to 300% FPL	Not Allowed. Financial eligibility is capped at 150% FPL, unless medically needy
Targeting sub-groups	Allowed	Allowed	Not allowed
Transition services	Allowed	Allowed	Allowed
MLTSS	Allowed	Allowed	Allowed
Participant direction	Allowed	Allowed	Required