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CMS Notifies States of Limited MOE Flexibility in HCBS Waiver Programs

Background

The Centers for Medicare & Medicaid Services (CMS) has issued a letter to state Medicaid agencies that identifies limited discretion states have to modify their home and community-based services (HCBS) waiver programs in lieu of the Affordable Care Act's (ACA) global Medicaid maintenance-of-effort (MOE) mandate.¹ Generally, CMS indicates in the letter that states may change the clinical eligibility standards in existing waivers so long as waiver recipients maintain their Medicaid eligibility and an equivalent level of HCBS services, and that states may make some broader eligibility changes to waivers that expire while the MOE mandate is in force. However, CMS emphasizes that changes that might not conflict with the ACA's Medicaid MOE mandate may still violate both the Americans with Disabilities Act (ADA) and other HCBS-specific MOE mandates that are connected to new programs and services authorized by the ACA. This brief provides an analysis of the guidance contained in the CMS letter.

The Maintenance-of-Effort Mandate

States have been subject to a broad Medicaid MOE mandate for nearly three years, beginning with the enactment of the American Recovery and Reinvestment Act of 2009 (ARRA).² In order to help relieve state budgetary pressures, ARRA made each state eligible for a substantial increase in federal Medicaid assistance so long as a state did not make its Medicaid "eligibility standards, methodologies, or procedures under its State plan [or waivers]" more restrictive than

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- 1 Letter from Cindy Mann, Director, CMS Center for Medicaid, CHIP, and Survey & Certification, to State Medicaid Directors (August 5, 2011) (hereafter, Letter, August 5, 2011), available at <http://www.cms.gov/smdl/downloads/SMD11-009.pdf>.
 - 2 Pub. L. No. 111-5.

those standards, methodologies, or procedures were as of July 1, 2008.³ ARRA's special federal Medicaid assistance was set to expire on December 31, 2010, but Congress extended it through June 30, 2011, by the enactment of the Education, Jobs and Medicaid Assistance Act of 2010.⁴

At the same time that ARRA's Medicaid MOE mandate was in force, the ACA was enacted into law.⁵ The central purpose of the ACA is to increase substantially the number of individuals with health insurance, which Congress chose largely to facilitate through an individual health insurance mandate that will become effective in 2014.⁶ In order to facilitate enrollment for the millions of uninsured who will be subject to the mandate, Congress charged states with the responsibility to establish health insurance exchanges where uninsured individuals can shop for an insurance plan. Included on the exchanges will be information on Medicaid eligibility, which will dramatically expand in 2014 to most individuals under the age of 65 whose household incomes are below 133% of the federal poverty level (FPL).⁷ The Medicaid expansion is anticipated to bring nearly 16 million new enrollees into the program by 2019.⁸

Thus, given how critical it is that state exchanges are operational when the individual mandate goes into effect in 2014, Congress incentivized state development of their exchanges by prohibiting a state from imposing, until its exchange is fully operational, "eligibility standards, methodologies, or procedures under the State [Medicaid] plan . . . or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment" of the ACA.⁹

Because the ACA was enacted when states were already subject to the ARRA Medicaid MOE mandate, the effect was that there were two different sources for the same mandate running concurrently through June 30, 2011, when the additional federal Medicaid assistance originally authorized by ARRA expired, and with it the MOE mandate that was attached. But the ACA mandate remains, so states are still bound to maintain their Medicaid eligibility standards until their health insurance exchanges are operational.

3 Id., at §5001(f)(1)(A). The increase in federal Medicaid assistance was in the form of a minimum 6.2 percentage point increase in each state's federal Medicaid reimbursement rate (FMAR).

4 Pub. L. No. 111-226, §201.

5 The Affordable Care Act is the general name used for the two separate laws enacted in March 2010 that comprise the health care reform legislation passed by Congress. The Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, was enacted on March 23, 2010, and the Healthcare and Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152, was enacted on March 30, 2010.

6 PPACA, at §1501(a)(2)(C) ("The requirement, together with other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services.").

7 Id., at §2001.

8 See Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker of the U.S. House of Representatives (March 20, 2010).

9 PPACA, §2001(b)(2), codified at 42 U.S.C. §1396a(gg)(1).

The Medicaid MOE Mandate and Coverage for LTSS

As CMS has recognized, the ARRA and ACA MOE mandates are almost identical. “In general, the Affordable Care Act MOE statutory provisions are very similar to the MOE provisions in . . . the American Recovery and Reinvestment Act. . . . Therefore, unless otherwise indicated, the Recovery Act MOE provisions and guidelines that have been issued by the Centers for Medicare & Medicaid Services . . . are applicable to implementation of the Affordable Care Act MOE provisions. . . .”¹⁰

In guidance CMS issued to states on the ARRA MOE mandate, CMS identified a number of LTSS-specific changes that states were prohibited from imposing. States could not reduce occupied waiver capacity for Section 1915(c) waivers, or reduce or eliminate section 1915(c) waiver slots that were approved, but unoccupied, as of July 1, 2008.¹¹ Additionally, states were prohibited from imposing new individual cost caps in their waivers that would have the effect of either terminating the eligibility of waiver recipients or hindering institutionalized residents from transitioning out of their facilities and into waivers.¹² And very importantly, CMS instructed states that they were prohibited from increasing the stringency of their HCBS waiver clinical eligibility standards.¹³

The clinical eligibility standard restriction was based on the standard’s connection to eligibility for HCBS waiver recipients. Generally, ARRA’s Medicaid MOE mandate, as read by CMS, did not bar states from eliminating services from state Medicaid plans or making the medical coverage requirements for available services more strict. In these situations, Medicaid enrollees would not lose their eligibility but instead only their access to particular services. However, CMS recognized that changing a waiver’s medical eligibility criteria could result in some enrollees losing their eligibility, because some waiver enrollees, in the absence of their waiver eligibility, would not be eligible for Medicaid at all.

To be eligible for a 1915(c) waiver, an individual must meet both an income and resource test and demonstrate that in the absence of waiver services, he or she will be institutionalized.¹⁴ States typically evaluate the latter element by comparing their nursing facility medical eligibility criteria to the needs of waiver applicants. For the income test, states are permitted to impose the “special income level” available to nursing facility residents. Generally, individuals 65 years old and older and adults with disabilities must have income at or below 100% of the federal poverty level (FPL) to attain categorical Medicaid eligibility (i.e, automatic eligibility). Otherwise, their state must have a “medically needy” category, under which prospective enrollees must significantly reduce their available income (“spenddown”) by incurring uncovered medical expenses. However, states are permitted to extend categorical eligibility to institutionalized individuals whose incomes are up

10 Letter from Cindy Mann, Director, CMS Center for Medicaid, CHIP, and Survey & Certification, to State Medicaid Directors 1 (February 25, 2011), available at <http://www.cms.gov/smdl/downloads/SMD11001.pdf>.

11 Centers for Medicare & Medicaid Services, American Recovery and Reinvestment Act of 2009 (ARRA) — Section 5001: Increased Federal Medical Assistance Percentage (FMAP) Factsheet 4 (March 25, 2009).

12 Id.

13 Id.

14 42 U.S.C. §1396n(c)(1).

to 300% of the Supplemental Security Income (SSI) benefit rate.¹⁵

A state that extends eligibility up to this level may also extend the same income limit to HCBS waiver applicants.¹⁶ Thus, for example, an individual 65 years old or older living in the community whose income is above 100% of the FPL but below 300% of SSI and whose resources are within the state's Medicaid limit will generally only qualify for Medicaid if her state has a medically needy category, but she will automatically qualify for Medicaid if she applies for a 1915(c) waiver and meets the waiver's clinical eligibility standard (and a waiver slot is available).

If after her waiver enrollment, however, the state heightens its institutional/HCBS waiver clinical standard and she does not meet it, she will lose her Medicaid eligibility altogether. While it is possible that she might regain eligibility for the waiver through a spenddown (if the state extends coverage under the waiver to the medically needy), there is no guarantee that she will be able to do so. Because of this direct connection between a waiver's clinical eligibility standard and Medicaid eligibility, CMS prohibited states under ARRA's MOE mandate from making waiver standards more stringent.

The Most Recent MOE Letter

While CMS previously stated that it would apply its ARRA Medicaid MOE guidelines to the ACA's, its recent letter identifies some discrete qualifications that specifically relate to states' HCBS programs. Most significantly, CMS informs states that it is possible that they can modify the clinical eligibility standards in HCBS waivers and provides in the letter three examples of circumstances where it may be permissible.

State adoption of the HCBS State Plan Benefit Categorical Group: First, CMS explains that a state's upward adjustment of its waiver clinical standard may be permissible where a state has adopted the new optional categorical population of HCBS state plan benefit recipients and extends coverage under the category to individuals who would have been eligible under the waiver's previous standard.¹⁷ Medicaid's HCBS state plan benefit, otherwise known as the "1915(i)" benefit, was authorized by the Deficit Reduction Act of 2005 and was designed to permit individuals with chronic conditions to receive a package of HCBS benefits similar to an HCBS waiver's benefit package without requiring the individuals to meet a state's institutional clinical standard.¹⁸ In the ACA, Congress authorized states to make 1915(i) benefit recipients a new categorical population, similar to the HCBS waiver categorical population, in that individuals not otherwise eligible under a separate eligibility category who meet the state's clinical standard for the benefit can

15 42 U.S.C. §§1396a(a)(10)(A)(ii)(V), 1396b(f)(4)(C).

16 42 U.S.C. §1396a(a)(10)(A)(ii)(VI).

17 Letter, August 5, 2011, Enclosure A, Answer to Question 2.

18 Pub. L. No. 109-171, §6086, codified at 42 U.S.C. §1396n(i) (Section 1915 of the Social Security Act).

automatically qualify for full Medicaid coverage.¹⁹ Additionally, while the DRA originally made the service package for the 1915(i) benefit smaller than what may be available in waiver packages, the ACA authorized states to make them comparable.²⁰

The scenario CMS appears to have in mind, with its suggestion that states may modify HCBS waiver clinical standards if affected individuals maintain a pathway to HCBS coverage through 1915(i), would work as follows. Assume a state requires that HCBS waiver applicants demonstrate a need for assistance with three activities of daily living to qualify, and the state wants to upwardly adjust the waiver test to four ADLs. If the state does, and it adopts the HCBS state plan categorical group and applies a three-ADL clinical test for eligibility, it may avoid a conflict with the MOE if all individuals who would otherwise have lost their Medicaid eligibility as a result of the change in the waiver clinical standard will remain eligible for Medicaid as members of the 1915(i) group. (Ironically, CMS' suggestion of the use of 1915(i) as a sort of patch for an upward increase in a state's HCBS waiver clinical standard was identified by the agency as being in conflict with the spirit of the 1915(i) benefit's original authorization.²¹)

Vermont and Rhode Island Tiered Standards: CMS states that an upward adjustment in a state's HCBS waiver standard is permissible in lieu of the MOE mandate where the change occurs in "a State that operates an 1115 waiver offering different levels of care for receipt of HCBS and institutional services, ensuring that the available capacity for Medicaid eligibility remains unchanged."²²

Generally, states apply only one clinical eligibility standard for access to institutional and HCBS waiver coverage. Vermont and Rhode Island, however, have both received permission to operate special waivers in which a three-tiered standard applies.²³ Both waivers identify the top two groups as "highest need" and "high need," while Vermont identifies its third tier as "moderate need" and Rhode Island's third tier is called "preventive need." Under both waivers, only those who meet the highest need standard are guaranteed coverage for benefits, while others only receive coverage if funding is available.

CMS' reference to these waivers as a possible basis for a permissible change in a waiver's clinical eligibility standard is very brief and without the descriptive example of the use of the 1915(i)

19 Pub. L. No. 111-148, §2402(d), codified at 42 U.S.C. §1396a(a)(10)(A)(ii)(XXII). It appears, however, that the maximum income limit for the HCBS state plan benefit categorical population is 150% of the FPL (unless a state participates in the Balancing Incentives Payments Program, described below). This will likely mean that, even where a state has adopted the new HCBS state plan categorical population, an upward adjustment in the waiver clinical eligibility standard will eliminate Medicaid eligibility for waiver enrollees with incomes above 150% of the FPL but below 300% of SSI.

20 Id., at §2402(c).

21 73 FR 18676, 18678 (April 4, 2008).

22 Letter, August 5, 2001, Enclosure A, Answer (b) to Question 2.

23 The Vermont and Rhode Island waivers were authorized under the special demonstration authority provided by 42 U.S.C. §1315 (Section 1115 of the Social Security Act).

benefit. The point seems to be that Vermont or Rhode Island may modify their highest need standards so as to render some current highest need waiver enrollees eligible only under the high or moderate/preventive levels, provided states ensure that the waiver's enrollment capacity does not change and the affected individuals remain enrolled in the waiver.

Waiver eligibility does not extend to “special income level” category: Finally, CMS explains that states may modify their clinical eligibility standards in waivers that do not offer coverage to special income level category.²⁴ Where this category is not included in a waiver, changes to the waiver's clinical standard do not result in the elimination of Medicaid eligibility, as many waiver enrollees qualify for Medicaid under separate categories (e.g., SSI recipients).

Other changes identified by CMS

Waiver Expiration: CMS indicates that other waiver-related actions are permissible in lieu of the MOE mandate. For example, CMS indicates that, where the term of a waiver expires while the Medicaid MOE is in effect, the MOE does not prevent a state from either letting the waiver lapse or requesting renewal under different terms, so long as states provide to CMS a “transition or phase-out plan” designed to minimize adverse impacts on affected individuals.²⁵

Service-specific standards: CMS explains that states may change the medical criteria that apply to individual waiver *services*.²⁶ Generally, the fact that a Medicaid applicant has established that he or she meets the clinical eligibility standard for a waiver does not mean that the individual will receive every service for which the state's waiver offers coverage; states may still apply medical criteria to a waiver service that the waiver enrollee must meet in order to have the service included in his or her benefit plan. These service-specific standards, CMS opines, are what may be modified.

Limitations

While identifying the discretion states have to make certain modifications to their HCBS waivers, CMS warns states that these same modifications may still violate other provisions of federal law.

ADA: The primary example advanced in the letter is the ADA. “[I]rrespective of whether there is an MOE issue, a reduction in benefits could potentially result in individuals losing the ability to have their needs met and live in a home and community-based setting, which could have implications under the ADA, the Olmstead decision, and subsequent Federal court decisions.”²⁷

24 Letter, August 5, 2001, Enclosure A, Answer (c) to Question 2.

25 Id., Answer to Question 3.

26 Id., Answer to Question 1.

27 Id.

BIPP and Community First-Choice: CMS also references the MOE requirements that are connected to certain ACA HCBS initiatives. Congress recognized in the ACA that Medicaid’s institutional bias has persisted, despite the enactment of the ADA and other federal initiatives.²⁸ To facilitate the expansion of HCBS, Congress authorized new HCBS opportunities for states to which it attached special federal financial assistance. Specifically, the State Balancing Incentives Payments Program (“BIPP”) and the Community-First Choice (CFC) benefit both include enhanced federal reimbursement rates for states that adopt them.²⁹ However, Congress attached LTSS-specific MOE mandates to both initiatives.

The BIPP program, which will run from October 2011 through September 2016, mandates, as a condition of eligibility for the program, that states “not apply eligibility standards, methodologies, or procedures *for determining eligibility for medical assistance for non-institutionally-based long-term services and supports* described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.”³⁰ (Emphasis provided)

“Non-institutionally-based” LTSS is defined in the BIPP provision to include, among others, home health services, personal care services, and services provided through an HCBS waiver.³¹ For waiver enrollees, this means that, at the very least, BIPP-participating states may not narrow the medical criteria of the services for which a waiver enrollee may receive coverage. With regard to the front-end eligibility criteria for the waiver itself, the BIPP MOE language is careful not to limit its application to *services*,³² and given that BIPP’s purpose is to expand HCBS, to glean from the BIPP MOE mandate authority for states to make the waiver eligibility criteria more restrictive would be to impose a very narrow interpretation on the MOE mandate that it is very likely in conflict with its purpose.

The ACA’s Community First-Choice MOE provision conditions state receipt of the enhanced FMAP available through the benefit to a state at least maintaining, during the first year in which it offers coverage for the benefit, “the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.”³³ This is a broad mandate that does

28 ACA, at §2406.

29 ACA, §§2401, 10202. For an overview of these provisions, see National Senior Citizens Law Center, The Medicaid Long-Term Services and Supports Provisions of the Patient Protection and Affordable Care Act, available at http://www.nslc.org/areas/medicaid/health-reform-ltss/at_download/attachment.

30 ACA, §10202(c)(3). The BIPP program permits participating states that have adopted the HCBS state plan benefit to extend coverage for the benefit to individuals whose incomes are up to 300% of the SSI benefit rate (§10202(c)(1)(B)).

31 *Id.*, at §10202(f)(1)(B).

32 Instead of prohibiting states from making more restrictive changes to the eligibility standards, methodologies and procedures *for such services*, the BIPP MOE language reads that the states may not make more restrictive changes to the “eligibility standards, methodologies, and procedures in effect *for such purposes* on December 31, 2010.”

33 ACA, §2401, codified at 42 U.S.C. §1396n(k)(3)(C).

not contain any eligibility-specific limitations. However, it prohibits a state that adopts CFC from reducing, for one year, Medicaid spending for people with disabilities and the elderly, which a state will risk doing if it adopts the CFC benefit and makes cuts to its HCBS waiver programs, whether through changes to eligibility or service rules.

Conclusion

The upshot of the CMS letter is that the current authority for states to make cuts to HCBS waiver programs is extremely limited, and that, ultimately, the exercise of this limited authority could be hostile to a state's interests. The substance of the letter does not reflect that the agency is seeking to offer more flexibility for states to reduce HCBS coverage. The ACA's MOE requirement remains in force until states have established their health insurance exchanges, and most states are unlikely to have them operational much before the January 1, 2014 deadline. Advocates should therefore continue to closely monitor their states' proposals to modify any elements of waivers that offer HCBS coverage.

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