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Key State Policy Choices About Medicaid Home and Community-Based Services

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Executive Summary

State Medicaid programs must cover long-term services and supports (LTSS) provided in nursing homes, while most home and community-based services (HCBS) are optional. State policy choices about HCBS shape these benefits in important ways for the seniors and people with disabilities who rely on them to live independently in the community. This issue brief presents the latest data (2017) from the Kaiser Family Foundation's 17th annual survey of Medicaid HCBS program policies in all 50 states and DC. Related briefs present state-level HCBS enrollment and spending data and answer key questions about HCBS waiver waiting lists. Key themes in state HCBS policies include the following:

- **States are using Medicaid HCBS to advance community integration and counter the historical bias toward institutional care.** For example, most states are using waivers to expand HCBS financial eligibility up to the federal maximum (300% SSI) and are using the same financial and functional eligibility criteria for HCBS and institutional care, placing HCBS on equal footing with nursing homes. A few waivers use less stringent financial and/or functional eligibility criteria compared to nursing homes, offering HCBS to these individuals before their needs rise to the more stringent (and often costlier) institutional level of care. States also are expanding the settings for personal care services beyond the beneficiary's home. Over 70% of states with the personal care state plan benefit offer services at a beneficiary's work site, and over 60% offer services elsewhere in the community outside of a home or work setting. Nearly all states allow beneficiaries to self-direct HCBS through at least one state plan or waiver authority.
- **States are using newer HCBS state plan authorities, including Section 1915 (i) and Community First Choice (CFC), to expand or augment the populations and services they are covering under waivers.** While the majority of HCBS continue to be provided through waivers, nearly all states that elect the CFC attendant services option also offer personal care state plan services, and nearly all states that elect the Section 1915 (i) HCBS state plan option also serve the same target populations through waivers. Section 1915 (i) targets people with functional needs that are less than an institutional level of care, which enables states to provide services earlier, before people's needs deteriorate to an institutional level of care, which may forestall or prevent the need for costlier more intensive services provided under waivers.
- **States are continuing to make policy changes in response to key federal regulations affecting HCBS.** Most of the 24 states with capitated managed long-term services and supports

programs already have put policies in place that follow changes in CMS's 2016 revision of the federal Medicaid managed care rule. States were further along in identifying policy changes required to come into compliance with CMS's home and community-based settings rule compared to the prior two years, with most having identified settings that must be modified to continue being used for Medicaid-funded HCBS, settings that cannot be modified and will require beneficiaries to relocate, and/or settings for which the state will submit information to CMS to overcome the presumption that they are institutional. An increasing number of states are making policy changes in response to the U.S. Department of Labor's application of minimum wage and overtime rules to direct care workers compared to the prior two years, such as by restricting worker hours or budgeting state funds for worker overtime and/or travel pay.

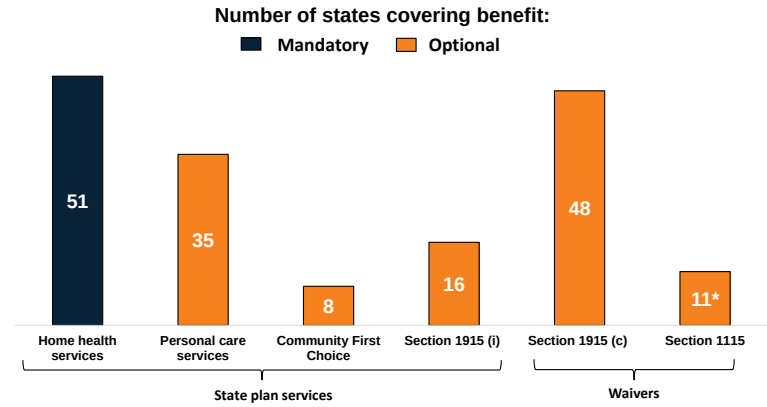
State HCBS policies have been instrumental in increasing beneficiary access to HCBS and shifting the balance of Medicaid LTSS spending in favor of HCBS over nursing homes and other institutional care. The historical bias toward institutions, requiring states to cover nursing home case while making most HCBS optional, remains in federal Medicaid law. Still, states continue to take advantage of various options to use federal Medicaid matching funds to increase HCBS eligibility and covered services and to modify their delivery systems and provider policies to support HCBS. As the primary payer for LTSS and the only source of many HCBS important to the daily needs and independent living of seniors and people with disabilities and chronic illnesses, Medicaid will continue to play an important role in this area, and state Medicaid HCBS policy choices will remain a key area to watch.

Introduction

State Medicaid programs must cover long-term services and supports (LTSS) provided in nursing homes, while most home and community-based services (HCBS) are optional.[1] In addition to choosing which HCBS to offer, states determine a number of policies that shape these benefits in important ways for the seniors and people with disabilities who rely on them to live independently in the community. This issue brief presents the latest (2017) data on key state policy choices from the Kaiser Family Foundation's 17th annual survey of Medicaid HCBS programs in all 50 states and DC. Our survey encompasses home health, personal care, Community First Choice, and Section 1915 (i) state plan benefits as well as Section 1915 (c) and Section 1115 waivers (Figure 1 and Appendix Table 1).

Figure 1

State policy choices about Medicaid HCBS program authorities, FY 2017.



NOTE: *Includes states with Section 1115 HCBS waivers without any accompanying Section 1915 (c) waivers.
SOURCE: Kaiser Family Foundation Medicaid HCBS Program Surveys, FY 2017.

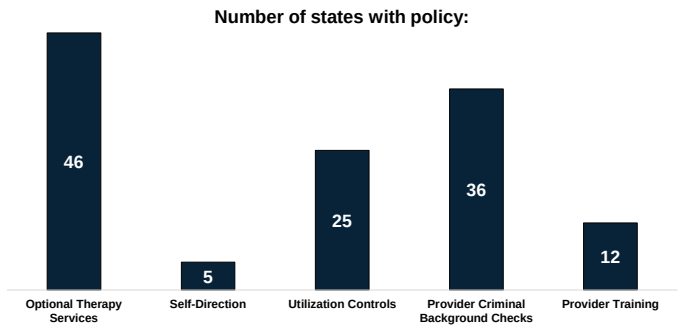
We include findings related to state choices about HCBS financial and functional eligibility criteria, scope of benefits, self-direction, utilization controls, provider policies and reimbursement rates, and quality measures. We also report on state progress in implementing notable regulations, including the LTSS provisions in the Medicaid managed care rule, the home and community-based settings rule, and the U.S. Department of Labor direct care worker minimum wage and overtime rule. The Appendix Tables contain detailed state-level data. Related briefs present the latest state-level Medicaid HCBS enrollment and spending data and key state policies related to HCBS waiver waiting lists.

Home Health State Plan Benefit Policies

All 51 states cover home health services in their state plan benefit package (Figure 1 and Appendix Table 1). These services are required for all states that choose to participate in Medicaid. At minimum, home health services include medical supplies, equipment, and appliances, nursing services, and home health aide services. Home health aide services typically assist individuals with self-care tasks, such as bathing or eating. Although states must cover home health services in their Medicaid programs, states make a number of policy choices that allow them to shape this benefit. Key state home health policy choices are described below and summarized in Figure 2 and Appendix Table 2.

Figure 2

State policy choices about Medicaid home health state plan services, FY 2017.



NOTES: Optional services include physical, occupational, and/or speech therapy. Utilization controls include caps on hours and/or amount spent on services.
SOURCE: Kaiser Family Foundation Medicaid State Plan Home Health Program Survey, FY 2017.

Most (46 of 51) states choose to expand the scope of their home health benefit by covering some optional therapy services (Figure 2 and Appendix Table 2). Most of these states (44) include all three therapy types (physical, occupational, and speech-language) in their home health benefit, in addition to the basic set of home health services listed in the preceding paragraph. In addition, 15 states choose to cover assistance with household activities, such as preparing meals or housekeeping, and nine states cover nutrition services, such as consultation with a dietitian and individualized meal plans, as part of their home health benefit (no data shown).

Few (5 of 51) states allow beneficiaries to self-direct home health services in 2017 (Figure 2 and Appendix Table 2), one state less than in 2016. Alaska and Louisiana discontinued self-direction of home health services, while Illinois added the benefit. Self-direction typically allows beneficiaries to select and dismiss their direct care workers, determine worker schedules, set worker payment rates, and/or allocate their service budgets. States may be less likely to offer self-direction for home health services compared to personal care services (discussed below) at least in part because home health services may

be used by some beneficiaries for shorter periods of time. Nebraska is the only state that allows self-direction for home health services but not for personal care services (Appendix Tables 2 and 3).

About half (25 of 51) states apply utilization controls to their home health benefit in 2017, down from 32 states doing so in 2016 (Figure 2 and Appendix Table 2). Specifically, in 2017, 21 states cap the number of home health hours that a beneficiary can receive, two states cap the amount that can be spent on home health services for a beneficiary, and two states apply both hour and spending caps. Among states making policy changes in this area, six (IN, KY, LA, NY, RI, and WA) discontinued hour caps, and two (AZ and MI) discontinued spending caps in 2017. Michigan retains its cap on home health service hours, while the other seven states with policy changes no longer report any home health utilization controls.

Nearly all (36) states require home health service providers to undergo criminal background checks, and about one-quarter (12 of 51) of states have provider training requirements in addition to federal regulations (Figure 2 and Appendix Table 2). Three states (FL, IL, and NY) report new provider training requirements in 2017. Among states that require provider training, California, Florida, and West Virginia each mandate one-time training of 75 hours, Kansas requires a 20-hour training course, and Indiana requires 12 hours of annual training.[2]

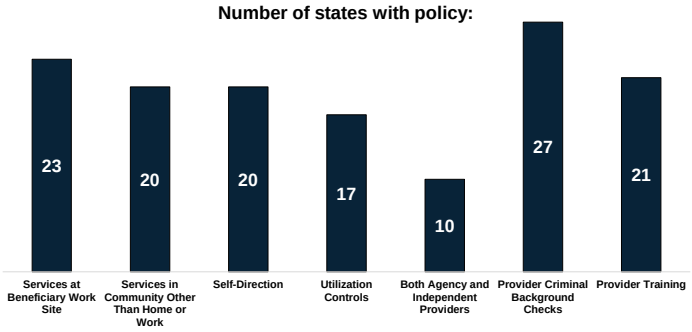
The average state reimbursement rate ($81.88/visit, Appendix Table 2) paid to home health agencies continued to decrease in 2017,[3] compared to 2016 ($92.52/visit), and 2015 ($93.93/visit). Agency rates account for a range of home health providers, such as registered nurses, home health aides, physical, occupational, and speech-language therapists, and social workers. Average rates per visit increased in states that paid home health service providers directly or mandated their reimbursement rates. Specifically, the average rate per visit increased from $83.29 in 2016, to $86.41 in 2017, in states that reported direct payment or mandated rates for registered nurses providing home health services.[4] Similarly, the average rate per visit increased from $42.56 in 2016, to $47.28 in 2017, in states that reported direct payment or mandated rates for home health aides.[5]

Personal Care State Plan Benefit Policies

Thirty-five states offer personal care services as an optional state plan benefit (Figure 1 and Appendix Table 1). Nearly all (31 of 32 responding[6]) of these states cover assistance with household activities, such as preparing meals or housekeeping, as part of their personal care benefit.[7] Sixteen states provide transportation, 16 states cover cueing or monitoring, and 11 states cover tasks delegated by a nurse, such as injections (no data shown). Other key state policy choices about personal care state plan benefits are summarized in Figure 3 and Appendix Table 3 and described below.

Figure 3

State policy choices about Medicaid personal care services, FY 2017.



NOTES: Utilization controls include caps on hours and/or amount spent on services.
SOURCE: Kaiser Family Foundation Medicaid State Plan Personal Care Program Survey, FY 2017.

In addition to a beneficiary's residence, nearly three-quarters (23 of 32) of states electing the personal care state plan option offer services at a beneficiary's work site (Figure 3 and Appendix Table 3). Twenty states provide personal care services elsewhere in the community outside of a home or work setting (Figure 3 and Appendix Table 3), and 16 states provide personal care services at residential care, foster care, or assisted living facilities (no data shown). Providing services at a work site or elsewhere in the community can increase the extent to which beneficiaries are integrated into the community.

Nearly two-thirds (20 of 32) of states allow beneficiaries to self-direct personal care services (Figure 3 and Appendix Table 3), four times the number that do so for home health services. As noted above, self-direction typically allows beneficiaries to select and dismiss their direct care workers, determine worker schedules, set worker payment rates, and/or allocate their service budgets. In 2017, two states (CO[8] and ME) newly reported that they allow beneficiaries to self-direct personal care services, and one state (Louisiana) reported that it stopped doing so.[9]

Over half (17 of 32) of states apply utilization controls to personal care services (Figure 3 and Appendix Table 3). Specifically, 16 states cap the number of hours that a beneficiary can receive, and one state (MO) caps the amount spent on personal care services that a beneficiary can receive. State policy choices about personal care services utilization controls were relatively stable from 2016 to 2017, with one state (FL) discontinuing hour and spending caps.

Nearly one-third (10 of 32) of states allow beneficiaries to choose among both agency and independent providers for personal care services (Figure 3 and Appendix Table 3). Covering more provider types can help increase beneficiary access to personal care services, which is especially critical

as beneficiaries often rely on these services for basic daily care. Seventeen states only cover agency providers, and three states offer only independent providers.

Nearly all (27 of 32) states require personal care service providers to undergo criminal background checks, and most (21) states require provider training (Figure 3 and Appendix Table 3). Twenty-two states require personal care attendants to be supervised, typically by nurses, provider agency staff, or case managers. Four states (CO, NC, NH, and RI) added supervision requirements in 2017, while one state (TX) no longer has this requirement. States determine supervision requirements for PCS services.

The average state reimbursement rate paid to personal care agencies increased slightly, from $19.01 per hour in 2016, to $21.03 per hour in 2017 (Appendix Table 3).[10] In states that paid personal care service providers directly or mandated their reimbursement rates, the average hourly rate was $16.70 in 2017, up from $14.32 in 2016.[11]

Community First Choice Policies

Eight states (CA, CT, MD, MT, NY, OR, TX, and WA) continue to offer attendant services and supports through the Community First Choice (CFC) state plan option (Figure 1 and Appendix Table 1). No state newly elected the CFC option in 2017. The CFC benefit was added by the Affordable Care Act (ACA) and became available to states in October 2011. It includes six percent enhanced federal matching funds. In addition to meeting financial eligibility criteria (described below), individuals receiving CFC services must have functional needs that would otherwise require an institutional level of care. CFC services must include assistance with self-care, household activities, and health-related tasks,[12] self-direction opportunities, and back-up systems.[13] States also may choose to cover other services under their CFC benefit, such as institutional to community transition costs[14] and supports that increase independence or substitute for human assistance.[15] Four (of 6 responding[16]) states (CT, MD, OR, and WA) cover both of these optional services; two states (MT and TX) do not cover CFC optional services.

Six states (CT, MT, NY,[17] OR, TX,[18] and WA) extend CFC financial eligibility to individuals who qualify for Medicaid under an HCBS waiver.[19] To be financially eligible for CFC services, an individual must either (1) be eligible for Medicaid in a state plan coverage group that includes nursing home services in the benefit package, or (2) have income at or below 150% of the federal poverty level (FPL, $18,735/year for an individual in 2019).[20] States can extend CFC eligibility to individuals who are eligible for Medicaid under an HCBS waiver; these waivers (described below) enable states to expand Medicaid financial eligibility up to 300% SSI ($27,756/year for an individual in 2019).[21]

Section 1915 (i) Policies

Ohio newly elected the Section 1915 (i) HCBS state plan option in 2017, joining 15 other states offering these services (CA, CO, CT, DE, DC, FL, ID, IN, IA, MD, MS, NV, OR, TX, and WI, Figure 1

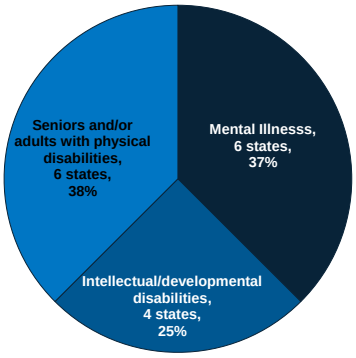
and Appendix Table 1). Section 1915 (i) allows states to offer HCBS as part of their Medicaid state plan benefit package instead of through a waiver. Like waivers, states can target Section 1915 (i) services to a particular population. Unlike waivers, states are not permitted to cap enrollment or maintain a waiting list for Section 1915 (i) HCBS. However, states can manage enrollment under Section 1915 (i) by restricting functional eligibility criteria if the state will exceed the number of beneficiaries that it anticipated serving. Functional eligibility for Section 1915 (i) HCBS requires beneficiaries to have needs that are less than what the state requires to qualify for an institutional level of care.

Maryland extends Section 1915 (i) financial eligibility to the federal maximum of 300% of SSI for certain beneficiaries, while the other 16 states elect the federal minimum of up to 150% FPL. Under Section 1915 (i), states can cover (1) people who are eligible for Medicaid under the state plan up to 150% FPL with no asset limit who meet functional eligibility criteria; and also may cover (2) people up to 300% SSI who would be eligible for Medicaid under an existing HCBS waiver.

People with mental illness and seniors/people with physical disabilities are the target populations most frequently served under Section 1915 (i) (Figure 4).[22] Six states (FL, IA, IN, OR, TX, and WI) target people with mental illness, six states target seniors and people with physical disabilities (CO, CT, DC, MD, NV, and OH), and four states target people with I/DD (CA, DE, ID, and MS).

Figure 4

State policy choices about Section 1915 (i) HCBS target populations, FY 2017



Total states with Section 1915 (i) option = 16

SOURCE: Kaiser Family Foundation Medicaid HCBS Program Survey, FY 2017.

Indiana continues to be the only state using Section 1915 (i) as an independent Medicaid coverage pathway.[23] This option allows individuals who are not otherwise eligible to gain Medicaid coverage. The other 16 states use Section 1915 (i) to authorize HCBS but require beneficiaries to be otherwise eligible for Medicaid through another coverage pathway.

Section 1915 (c) and Section 1115 HCBS Waiver Policies

Medicaid HCBS waiver authorities include Section 1915 (c) and Section 1115. Both allow states to expand financial eligibility and offer HCBS to seniors and people with disabilities who would otherwise qualify for an institutional level of care. Section 1115 also enables states to deliver HCBS through capitated managed care and to serve multiple target populations in a single waiver.

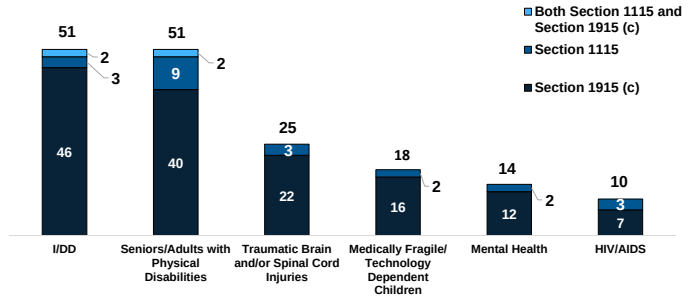
Population served

All 51 states offer a total of 287 HCBS waivers targeted to different populations (Appendix Tables 4 and 5). The vast majority (276 waivers in 48 states) continue to be Section 1915 (c) waivers (Figure 1 and Appendix Table 4). A minority (11 waivers in 11 states) are Section 1115 waivers[24] (Figure 1 and Appendix Table 5). Eight of the Section 1115 waiver states (CA, DE, HI, NJ, NM, NY, TN, and TX) serve some HCBS populations under that authority and other HCBS populations through Section 1915 (c) waivers. The other three Section 1115 waiver states (AZ, RI, and VT) use that authority to provide HCBS to all covered populations and do not offer any Section 1915 (c) waivers. Unlike Section 1915 (c) waivers, Section 1115 waivers enable state to require HCBS beneficiaries to enroll in capitated managed care and to serve multiple target populations in a single waiver.

The number of Section 1915 (c) waivers averages six per state and ranges from one to 11, depending on the number of populations targeted (Appendix Table 4). Some states, such as Delaware, Hawaii, and New Jersey, operate only one Section 1915 (c) waiver and use Section 1115 capitated managed care waivers for other HCBS populations. On the other end of the range, Colorado operates 11 Section 1915 (c) waivers, and four states (CT, MA, MO, and NY) each offer 10 Section 1915 (c) waivers targeted to different populations. Section 1115 waiver states each operate one such waiver but, unlike Section 1915 (c), may serve multiple populations through a single waiver (Appendix Table 5).

Figure 5

State policy choices about Medicaid HCBS waiver target populations, 2017.



NOTE: I/DD = intellectual and development disabilities. States may offer more than one Section 1915 (c) waiver per target population category.
SOURCE: Kaiser Family Foundation Medicaid HBCS Waiver Program Survey, FY 2017.

All 51 states serve people with intellectual and developmental disabilities (I/DD), seniors, and nonelderly adults with physical disabilities through HCBS waivers (Figure 5, Appendix Tables 4 and 5). For the I/DD population, 46 states use Section 1915 (c) waivers, three states (AZ, RI, and VT) use Section 1115 waivers, and 2 states (NY and TN) use both waiver authorities. One state (DE) expanded its Section 1915 (c) I/DD waiver population in 2017 to include those living in the family home. For seniors and adults with physical disabilities, 40 states use Section 1915 (c) waivers,[25] nine states (AZ, DE, HI, NJ, NM, RI, TN, TX, and VT) use Section 1115 waivers, and two states (CA and NY) use both waiver authorities.

A minority of states use HCBS waivers to serve people with traumatic brain and/or spinal cord injuries (TBI/SCI, 25), children who are medically fragile or technology dependent (18), people with mental health disabilities (14), and people with HIV/AIDS (10) (Figure 5, Appendix Tables 4 and 5). Nearly all (22 of 25) states with TBI/SCI waivers use Section 1915 (c), while three (DE, RI, and VT) use Section 1115.[26] Most (16 of 18) waivers that target children who are medically fragile or technology

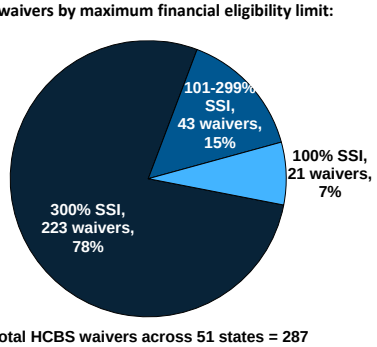
dependent are under Section 1915 (c), while two states (HI and RI) use Section 1115.[27] Most (12 of 14) mental health HCBS waiver states use Section 1915 (c), while two states (DE and RI) use Section 1115. Seven of 10 states using HCBS waivers to cover people with HIV/AIDS use Section 1915 (c) authority, while three states (DE, HI, and RI) use Section 1115 for this population.

Eligibility

Over three-quarters (78%, 223 of 287) of HCBS waivers set financial eligibility at the federal maximum (Figures 6 and 7, Appendix Table 6). States can use waivers to expand HCBS financial eligibility to a maximum of 300% of SSI ($2,313/month for an individual in 2019). Seven percent of HCBS waivers (21 in 8 states) set financial eligibility at 100% of SSI ($771/month for an individual in 2019). There was little change in state choices about HCBS waiver financial eligibility limits from 2016 to 2017.

Figure 6

State policy choices about Medicaid HCBS waiver financial eligibility limits, FY 2017.

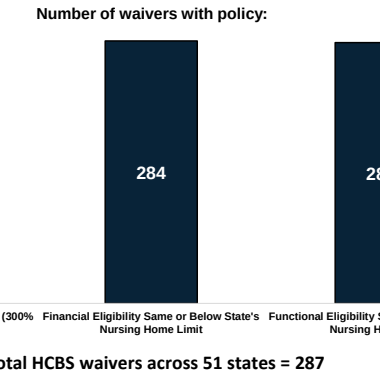


NOTES: 100% SSI = $9,252/year for an individual in 2019. 300% SSI = 27,756/year for an individual in 2019. HCBS waivers include Section 1915 (c) and Section 1115. Total may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation Medicaid HBCS Waiver Program Survey, FY 2017.

Nearly all (99%, 284 of 287) HCBS waivers set financial eligibility limits at or below the nursing home limit (Figure 7). Most HCBS waivers (89%, 254 in 48 states) waivers use the same financial eligibility criteria as are required for nursing home eligibility. Another 30 HCBS waivers in 12 states (10% of all waivers) use financial eligibility criteria that are less stringent than those required for institutional care. Only three waivers in three states (CO, MD, and ND, 1% of all waivers) use financial eligibility criteria that are more restrictive than those required for institutional care. Two of these waivers (CO I/DD and MD seniors/adults with physical disabilities) set functional eligibility comparable to institutions, although financial eligibility is more restrictive than institutions. The other waiver (ND medically fragile children) has more restrictive financial and functional eligibility criteria (discussed below) compared to institutions. Using the same financial eligibility for HCBS waivers and institutional care removes any potential bias in favor of institutional care, which can occur if an individual must have less income and/or assets to receive HCBS than to receive institutional services.

Figure 7

State policy choices about Medicaid HCBS waiver eligibility, FY 2017.



NOTES: HCBS waivers include Section 1915 (c) and Section 1115. 300% SSI = 27,756/year for an individual in 2019.
SOURCE: Kaiser Family Foundation Medicaid HBCS Waiver Program Survey, FY 2017.

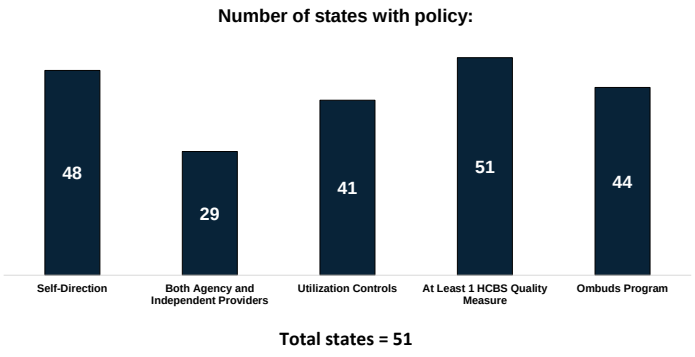
Nearly all (98%, 282 of 287) HCBS waivers use functional eligibility criteria that are the same as or less stringent than the criteria to qualify for nursing home services (Figure 7). Most (94%, 270 in 51 states) HCBS waivers use the same functional eligibility criteria as are required for nursing facility eligibility, treating HCBS and institutional care equally. Another 12 HCBS waivers in eight states (4% of all waivers) use functional eligibility criteria that are less stringent than those required for institutional care. Five waivers in three states (CA, ND, and SC, 2% of all waivers) use functional eligibility criteria that are more restrictive than those required for institutional care. Four of these waivers (CA medically fragile children, and SC HIV/AIDS, adults with physical disabilities, and seniors/adults with physical disabilities) set financial eligibility the same as for institutions, even though functional eligibility is more restrictive. Functional eligibility criteria typically include the extent of assistance needed to perform self-care (such as eating, bathing, or dressing) and/or household activities (such as preparing meals or managing medications). Using the same functional eligibility for HCBS waivers and institutional care removes any potential bias in favor of institutional care, which can occur if an individual must have greater functional needs to receive HCBS than to receive institutional services.

Self-Direction

Nearly all states (48 of 51) allow beneficiaries in at least one HCBS waiver to self-direct services (Figure 8 and Appendix Table 8). Self-direction is available statewide in 47 of 48 states; the exception is Mississippi. Three states (AK, AR, and NV) do not allow HCBS waiver self-direction. In all 48 self-direction states, beneficiaries can select, train, and dismiss direct care workers and set worker schedules.[28] In 38 states, beneficiaries can decide how to allocate their service budgets, and in 35 states, beneficiaries can determine worker payment rates.[29]

Figure 8

State policy choices about Medicaid HCBS waiver benefits and oversight, FY 2017.



NOTES: HCBS waivers include Section 1915 (c) and Section 1115. Utilization controls include limits on hours, amount spent on services, and/or geographic area.
SOURCE: Kaiser Family Foundation Medicaid HBCS Waiver Program Survey, FY 2017.

Among states making policy changes related to self-direction in 2017, one state (AK) stopped allowing self-direction in HCBS waivers, three states (GA, MO, and TX) began allowing beneficiaries to allocate their service budgets, and one state (MO) began allowing beneficiaries to determine worker payment rates.[30]

The majority (29 of 48) of states offering waiver self-direction allow beneficiaries to choose either agency-employed or independent providers (Figure 8 and Appendix Table 8). Fifteen states (DE, GA, HI, IN, IA, LA, MS, OK, OR, RI, TN, UT, VT, VA, and WY) offer only independent providers, and four states (DC, MD, SD, and WV) offer only agency providers. Thirty-five states allow certain family members to be paid providers, typically those who are not the beneficiary's spouse or legally responsible relative.

Utilization Controls[31]

Eighty percent (41 of 51) of states use utilization controls in their HCBS waivers[32] (Figure 8 and Appendix Table 9). Nineteen states use more than one type of cost control, including 15 states (ID, IA, KY, LA, MD, MA, MO, NM, NC, OK, SC, SD, TX, WV, and WY) with caps on both the amount spent and the number of service hours, three states (CO, MN, and NY) with both spending and geographic limits, and one state (CA) with all three types of utilization controls. Another 18 states use spending amount caps only, such as limiting the cost of HCBS to a percentage of the nursing facility reimbursement rate. Four states (AK, DC, MI, and NE) use hourly service caps only, such as day, week, annual or lifetime limits; services to which states apply hourly service caps include personal care, respite, chore/homemaker, adult day, physical/occupational/speech therapy, and supported employment. The 10 states without any HCBS waiver service utilization controls include AR, GA, HI, MS, NV, OR, UT, VT, VA, and WI. Among states making utilization control policy changes in 2017, five (CA, MI, MO, SC, and SD) added hour limits, and one (GA) added a spending limit. Three states (ME, MN, and PA) discontinued hour limits, one state (VA) discontinued a spending limit, and one state (WA) discontinued geographic limits.

State cost control policies vary by waiver target population with most spending caps (48%) and service hour limits (59%) applying to waivers targeting people with I/DD. Over one-third (35%) of spending caps and about one-quarter of service hour limits apply to waivers targeting seniors and/or adults with physical disabilities. Waivers targeting people with TBI/SCI accounted for 8% of spending caps and 9% of service hour limits.

Quality Measures

All states had at least one HCBS waiver quality measure in place (Figure 8). HCBS quality measures vary by state but typically do not vary by waiver within a state. Most states rely on a combination of beneficiary experience data (to assess measures such as community participation/inclusion, choice and control, or employment) and performance measures (to assess measures such as level of care determinations, provider qualifications, service plans, enrollee health and welfare, and financial compliance) outlined in their Section 1915 (c) waiver applications. Relatedly, the Medicaid managed care rule (discussed below) requires states that provide managed LTSS to identify standard performance measures related to quality of life, rebalancing, and community integration for health plan contracts beginning on or after July 1, 2017.[33]

Forty-eight states measure beneficiary quality of life (Appendix Table 9). To do so, states use tools such as the National Core Indicators – Aging and Disability (NCI-AD) survey,[34] the CAHPS HCBS survey,[35] and other consumer satisfaction surveys. For example, Washington uses the NCI-AD survey to measure the percentage of waiver participants and family members who indicate satisfaction with their service providers as well as the percentage of service plans that identify personal goals for waiver participants.

Forty-two states have quality measures related to community integration (Appendix Table 9). States assess community integration through the NCI-AD survey, care plan reviews to evaluate person-centeredness, or monitoring beneficiary choice of service providers.

Seventeen states use LTSS rebalancing measures (Appendix Table 9). These states draw on annual needs assessment data or the Money Follows the Person rebalancing benchmarks. In Arizona's Section 1115 waiver, there are financial incentives for HCBS included in the per-member-per month blended capitation rate for HCBS and institutions, with state monitoring to ensure that HCBS rebalancing targets are met. Arizona currently has 87 percent of its LTSS population living in a home and community-based setting, including 68 percent who live in their own home.

Ombuds Programs

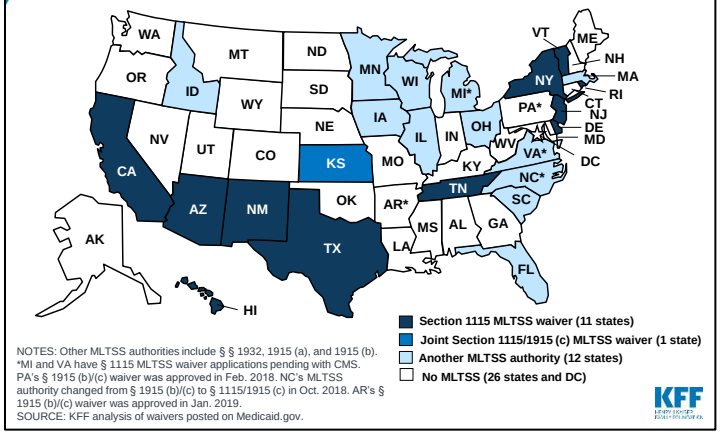
Forty-four states have an ombudsman program, typically as part of state government (37 states), to assist Medicaid beneficiaries receiving HCBS (Figure 8 and Appendix Table 9). Six states (LA, MS, NM, WA, WI, and WY) reported ombudsman programs located both within and outside of state government. Ombudsman programs may provide enrollment options counseling, assist beneficiaries with health plan appeals, offer information about state fair hearings, track beneficiary complaints, train health plans and providers about community-based services and supports that can be linked with Medicaid-covered services, and report data and systemic issues to states. The 2016 Medicaid managed care rule requires states using capitated MLTSS to offer an independent beneficiary support system, in health plan contracts beginning on or after July 1, 2018, that provides the following services for people who use or wish to use LTSS: (1) an access point for complaints and concerns; (2) education on enrollee rights and responsibilities; (3) assistance in navigating the grievance and appeals process; and (4) review and oversight of data to guide the state in identifying and resolving systemic LTSS issues.[36]

LTSS Provisions in the Medicaid Managed Care Rule

Twenty-four states have capitated managed long-term services and supports (MLTSS) programs that include HCBS in 2017 (Figure 9). These include the 11 states that provide HCBS through Section 1115 MLTSS waivers (described above), and 13 states that use another MLTSS program authority. We surveyed these 24 states to gauge progress with implementing key LTSS provisions of the Medicaid managed care regulations. Box 1 provides background on these regulations. Key findings related to state MLTSS policies are described below and summarized in

Figure 9

States with capitated Medicaid MLTSS programs, 2017.



NOTES: Other MLTSS authorities include § § 1932, 1915 (a), and 1915 (b). *MI and VA have § 1115 MLTSS waiver applications pending with CMS. PA's § 1915 (b)/(c) waiver was approved in Feb. 2018. NC's MLTSS authority changed from § 1915 (b)/(c) to § 1115/1915 (c) in Oct. 2018. AR's § 1915 (b)/(c) waiver was approved in Jan. 2019.
SOURCE: KFF analysis of waivers posted on Medicaid.gov.

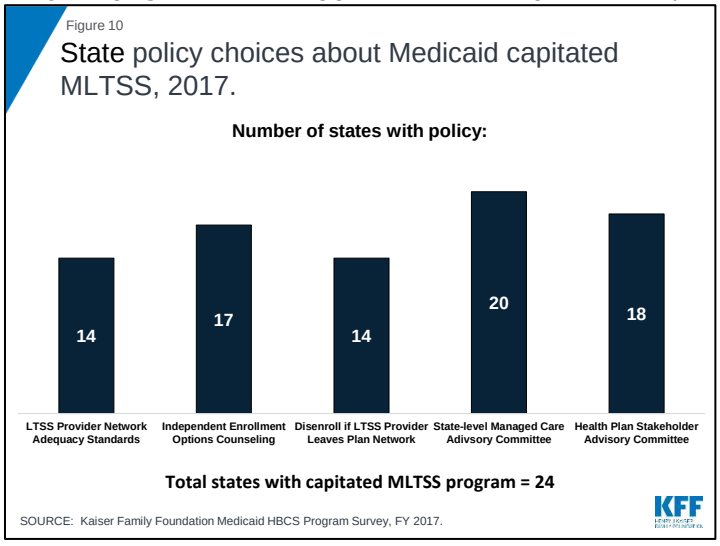
Figure 10 and Appendix Table 10. State MLTSS policies were relatively stable from 2016 to 2017.

Box 1: Background on Medicaid Managed Care Regulations Affecting LTSS

The 2016 revision of the Medicaid managed care regulations, issued under the Obama Administration, addressed capitated MLTSS programs for the first time. It included new provisions for independent enrollment choice counseling, disenrollment for cause if an LTSS provider leaves the health plan network, LTSS provider network adequacy standards, and stakeholder advisory committees; different provisions of the regulations have different effective dates.[37] Subsequently, under the Trump Administration, CMS proposed some changes to the 2016 regulations, most notably to the network adequacy standards.[38] The proposed changes were issued in November 2018, and the public comment period closed in January 2019. CMS also issued a June 2017 informational bulletin indicating that it "intends to use [its] enforcement discretion. . . when states are unable to implement new and potentially burdensome requirements of the final [managed care] rule by the required compliance date, particularly provisions with a compliance deadline of contracts beginning on or after July 1, 2017," while changes to the managed care regulations are pending.[39]

LTSS Network Adequacy Standards

Fourteen states (58% of the 24 MLTSS states) require network adequacy standards for LTSS providers in 2017, up from 13 states the prior year (Figure 10 and Appendix Table 10). For example, Texas has time and distance requirements. Arizona and Florida require geographic location standards in addition to time and distance. Delaware's Section 1115 waiver specifies maximum time from service authorization to service implementation, including no more than 60 days for minor home modifications, no more than 10 days for home delivered meals, and 10 days for new beneficiaries (or immediately for nursing facility beneficiaries transitioning to the community) for personal care attendant services.



The 2016 managed care regulations require states to develop time and distance standards for MLTSS providers when the enrollee must travel to the provider, and network adequacy standards other than time and distance standards for MLTSS providers that travel to the enrollee to deliver services. These

standards are required for health plan contracts beginning on or after July 1, 2018.[40] However, CMS's November 2018 proposed rule would remove the requirement for time and distance standards and instead would allow states to choose another quantitative standard, such as minimum provider-to-enrollee ratios, maximum travel time or distance to providers, minimum percentage of contracting providers accepting new patients, maximum wait times for an appointment, or hours of operation requirements.[41]

Independent Enrollment Options Counseling

Seventeen states (71% of the 24 MLTSS states) provide MLTSS enrollees with independent enrollment options counseling (Figure 10 and Appendix Table 10). Some states contract with a third party enrollment broker, while others rely on community-based organizations such as aging and disability resource centers. A couple (AZ and IA) provide this service through the state Medicaid agency. Delaware reported plans to expand this service in 2018, while Minnesota also noted plans to improve beneficiary access to options counseling by broadening the service in order "to come more fully into compliance with the managed care regulation." CMS's 2016 Medicaid managed care regulations require all states to offer enrollee choice counseling through the independent beneficiary support system required in health plan contracts beginning on or after July 1, 2018.[42] Options counseling seeks to help MLTSS enrollees select a health plan; this population may not be familiar with that process because they traditionally have been enrolled in the fee-for-service delivery system. MLTSS enrollees also may seek assistance with choosing a health plan to find a provider network that best meets their various needs – which may go beyond primary care to include specialists, behavioral health providers, durable medical equipment suppliers, and personal care attendants -- and preserves their existing provider relationships to the extent possible.

Disenrollment If LTSS Provider Leaves Plan Network

Fourteen states (58% of the 24 MLTSS states) allow MLTSS beneficiaries to disenroll from their health plan if their residence or employment would be disrupted due to an LTSS provider leaving the plan network in 2017 (Figure 10 and Appendix Table 10), one more state than the prior year. Under the 2016 Medicaid managed care regulations, states must consider these circumstances as good cause for disenrollment for health plan contracts beginning or after July 1, 2017.[43] In Arizona, individuals cannot choose to disenroll from a health plan for employment disruptions; however, if a skilled nursing facility or assisted living facility exits the health plan network, the plan is required to pay for these services until the individual's next open enrollment period in order to mitigate disruption in residential placement. Individuals can then choose either another plan contracted with the provider or choose another residential placement.

Stakeholder Advisory Committees

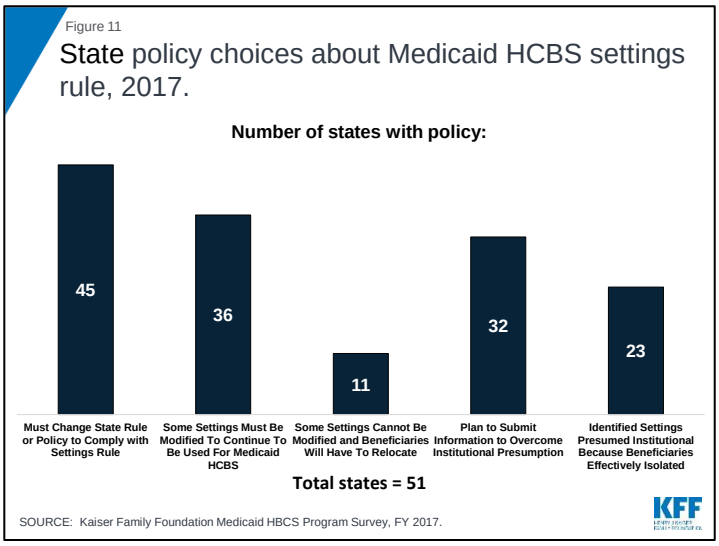
Twenty states (83% of the 24 MLTSS states) had a state-level managed care advisory committee, and 18 states (75%) required health plans to have a stakeholder advisory committee (Figure 10 and Appendix Table 10). In Delaware, managed care plans are required to have a provider advisory committee in addition to a member advisory committee. The 2016 Medicaid managed care regulations

require states to create and maintain a stakeholder group to solicit and address the opinions of beneficiaries, individuals representing beneficiaries, providers, and other stakeholders in the design, implementation, and oversight of a state's MLTSS program. In addition, health plans providing MLTSS must have a member advisory committee that includes at least a reasonably representative sample of the populations receiving LTSS covered by the plan or other individuals representing those enrollees. These provisions are effective for health plan contracts beginning on or after July 1, 2017.[44]

HCBS Settings Rule

States were further along in the process of identifying policy changes necessary to come into compliance with CMS's home and community-based settings rule in 2017, compared to the previous two years. CMS's January 2014 rule defines the qualities of residential and non-residential settings in which Medicaid-funded HCBS can be provided.[45] To be considered community-based, settings must support an individual's full access to the greater community; be selected by the individual from options including non-disability specific settings; ensure individual privacy, dignity, respect and freedom from coercion or restraint; optimize individual autonomy in making life choices; and facilitate individual choice regarding services and providers. Additional criteria apply to provider-owned or controlled settings. In May 2017, CMS extended the state compliance deadline by three years, to March, 2022, but retained the March 2019 deadline for states to submit transition plans.[46] As of March 2019, 13 states (AK, AR, DE, DC, ID, KY, MN, ND, OK, OR, TN, WA, and WY) have received final CMS approval on their transition plan.[47] Another 29 states have received initial approval from CMS.[48]

Forty-five states anticipate having to change state rules or policies to come into compliance with the settings rule in 2017, up from 42 states in 2016 (Figure 11 and Appendix Table 11). Four states (AK, DC, NY, and VT) joined this list in 2017, while Florida anticipated changes in 2016 but not 2017. Specifically, 36 states have identified some settings that will have to be modified in some way to continue to be used for Medicaid-funded HCBS (up from 13 states in 2015, and 35 states in 2016). The number of settings that must be modified varies substantially by state, ranging from the single digits, to several hundred, to one thousand or more. Additionally, 11 states identified settings that cannot be modified to meet the settings rule and consequently will require beneficiaries to be relocated to continue receiving Medicaid-funded HCBS (up from 2 states in 2015, and down from 16 states in 2016). Relatively few settings per state fall into this category.



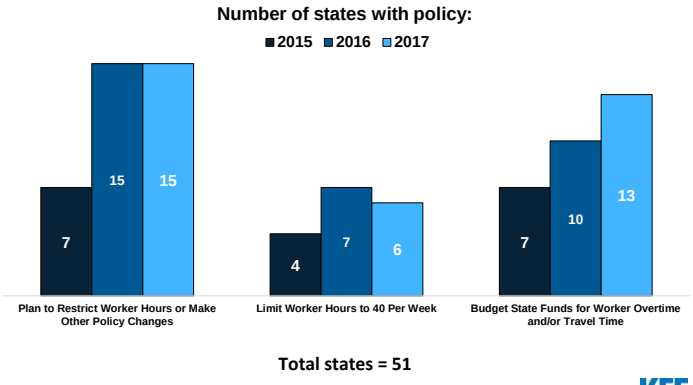
Thirty-two states plan to submit information to the HHS Secretary to overcome the rule's presumption that a specific setting is institutional so that Medicaid-funded HCBS can continue to be provided there, up from 11 states in 2015, and 28 states in 2016 (Figure 11 and Appendix Table 11). The number of settings for which each state plans to seek to overcome the institutional presumption ranges from the single digits to nearly 200. The settings rule presumes that certain settings are not community-based because they have institutional qualities, such as those in a facility that provides inpatient treatment, those on the grounds of or adjacent to a public institution, and those that have the effect of isolating individuals from the broader community. The Secretary can overcome the institutional presumption for these settings by applying heightened scrutiny based on information submitted by the state.[49] Twenty-three states have identified settings that are presumed institutional because they effectively isolate beneficiaries, up from 10 states in 2015, and 22 states in 2016. Most states have relatively few settings in this category.

Direct Care Worker Minimum Wage and Overtime Rule

Fifteen states planned to restrict worker hours or make other policy changes in 2017, in response to the U.S. Department of Labor (DOL) minimum wage and overtime rules (Figure 12 and Appendix Table 11), up from seven states that reported doing so in 2015. States reporting a policy change in 2017 include CA, IA, KS, KY, ME, ND, NH, NM, OH, OK, OR, VA, WA, WI, and WY; 11 of these states (all but ME, ND, OH, and VA) also reported a policy change in this area in 2016. DOL extended the Fair Labor Standards Act minimum wage and overtime rules to most direct care workers, such as certified nursing assistants, home health aides, personal care aides, and other caregivers, who previously were exempt from those requirements; the new rules took effect in 2015.[50] CMS policy guidance issued in 2014 anticipated that the new DOL rules could affect self-directed Medicaid HCBS and observed that "many states will need to develop policies and consider programmatic changes to address the costs related to overtime and/or worker time spent traveling between worksites (i.e., individuals' homes), to avoid or minimize negative impacts to individual [service] budgets, and to preserve the ability of individuals to self-direct services and supports effectively."[51]

Figure 12

State policy choices about DOL direct care worker minimum wage and overtime rule, 2017.



SOURCE: Kaiser Family Foundation Medicaid HBCS Program Surveys, FY 2015-2017.

Among the states reporting policy changes in response to the DOL rule, six (IA, ME, NM, OK, WI, and WY) limited worker hours to 40 per week (Figure 12 and Appendix Table 11). Five of these states had this policy in 2016, with one state (ME) joining this list in 2017. In Oklahoma, beneficiaries are encouraged to have more than one direct caregiver, since no one caregiver is permitted to work over forty hours per week. In California, participants who are authorized for more than 360 hours a month of

combined state plan and/or waiver personal care services must receive care from two or more providers. Other states allow worker overtime only if certain conditions are met. For example, two states allow providers with a history of overtime hours to work a limited amount of overtime (up to 50 hours per week in Oregon, and up to 65 hours per week in Washington[52]).

Thirteen states reported budgeting state funds for worker overtime and/or travel time pay as a result of the DOL rule (Figure 12 and Appendix Table 11), up from ten states in the prior year. Specifically, 10 states (AL, CA, CT, IL, MA, MS, NE, OR, SC, and WA) budgeted funds for both direct care worker overtime and travel pay in in 2017. Seven of these 10 states did so last year, and three states (CT, MS, and OR) began doing so this year. For example, Illinois pays 1.5 times the basic hourly pay rate in order to cover travel time from one Medicaid beneficiary's home to another individual's home. Three states (KY, PA, and WI) budgeted funds for overtime only, both last year and this year.

Looking Ahead

States are using Medicaid HCBS to advance community integration and counter the historical bias toward institutional care through policies such as financial and functional eligibility and expanding the care settings where HCBS are available beyond the beneficiary's home to work and other community settings. States also are using newer HCBS state plan authorities, including Section 1915 (i) and CFC, to expand or augment the populations and services they cover under waivers. Section 1915 (i) enables states to reach people with functional needs that do not yet rise to an institutional level of care, using HCBS to potentially prevent or delay the need for costlier care in the future. States also are continuing to make policy changes in response to key federal regulations affecting HCBS.

State HCBS policies have been instrumental in increasing beneficiary access to HCBS and shifting the balance of Medicaid LTSS spending in favor of HCBS over nursing homes and other institutional care. The historical bias toward institutions, requiring states to cover nursing home case while making most HCBS optional, remains in federal Medicaid law. Still, states continue to take advantage of various options to use federal Medicaid matching funds to increase HCBS eligibility and covered services and to modify their delivery systems and provider policies to support HCBS. As the primary payer for LTSS and the only source of many HCBS important to the daily needs and independent living of seniors and people with disabilities and chronic illnesses, Medicaid will continue to play an important role in this area, and state Medicaid HCBS policy choices will remain a key area to watch.

Appendix Tables

Appendix Table 1: State Adoption of Medicaid HCBS by Program Authority, FY 2017

Appendix Table 2: State Policy Choices for Medicaid Home Health State Plan Benefits, FY 2017

Appendix Table 3: State Policy Choices for Medicaid Personal Care State Plan Benefits, FY 2017

Appendix Table 1: State Adoption of Medicaid HCBS by Program Authority, FY 2017						
	State Plan Services				Waivers	
State	Home health	Personal care	Community First Choice	Section 1915 (i)	Section 1915 (c)	Section 1115*
Alabama	X				X	
Alaska	X	X			X	
Arizona	X					X
Arkansas	X	X			X	
California	X	X	X	X	X	X
Colorado	X	X		X	X	
Connecticut	X		X	X	X	
Delaware	X	X**		X	X	X
DC	X	X		X	X	
Florida	X	X		X	X	
Georgia	X				X	
Hawaii	X				X	X
Idaho	X	X		X	X	
Illinois	X				X	
Indiana	X			X	X	
Iowa	X			X	X	
Kansas	X	X**			X	
Kentucky	X				X	
Louisiana	X	X			X	
Maine	X	X			X	
Maryland	X	X	X	X	X	
Massachusetts	X	X			X	
Michigan	X	X			X	
Minnesota	X	X			X	
Mississippi	X			X	X	
Missouri	X	X			X	
Montana	X	X	X		X	
Nebraska	X	X			X	
Nevada	X	X		X	X	
New Hampshire	X	X			X	
New Jersey	X	X			X	X
New Mexico	X	X**			X	X
New York	X	X	X		X	
North Carolina	X	X			X	X
North Dakota	X	X			X	
Ohio	X			X	X	
Oklahoma	X	X			X	
Oregon	X	X	X	X	X	
Pennsylvania	X				X	
Rhode Island	X	X				X
South Carolina	X				X	
South Dakota	X	X			X	
Tennessee	X				X	X
Texas	X	X	X	X	X	X
Utah	X	X			X	
Vermont	X	X				X
Virginia	X				X	
Washington	X	X	X		X	
West Virginia	X	X			X	
Wisconsin	X	X		X	X	
Wyoming	X				X	
TOTAL:	**51**	**35**	**8**	**16**	**48**	**11**

NOTES: *Includes states with § 1115 waivers without any accompanying § 1915 (c) waivers. **DE, KS, and NM deliver personal care state plan services through their Section 1115 capitated managed care waivers and do not separately report on state plan personal care enrollment, spending, or program policies.
SOURCE: KFF Medicaid HCBS Program Surveys, FY 2017.

Appendix Table 2: State Policy Choices for Medicaid Home Health State Plan Benefits, FY 2017									
State	Optional Therapy Services*	Self-Direction	Utilization Controls		Provider Criminal Background Checks	Provider Training	Provider Reimbursement Rates (per visit, unless noted as per hour)		
			Cost Cap	Hour Cap			Agency	Registered Nurse	Home Health Aide
Alabama	X			X	X		$27.00/hr		
Alaska					X		$169.36		
Arizona					X				$10.00/hr
Arkansas	X							$145.02	$66.63
California	X	X		X	X	X		$74.86	$45.75
Colorado	X		X		X			$103.63	$36.85/hr
Connecticut	X	X	X	X		X	$95.20/hr		$24.64/hr
Delaware	X				X				
DC	X			X	X	X	$60.00	$90.00	$20.20/hr
Florida	X			X	X	X		$31.04	$17.46
Georgia	X			X			$61.32	$61.32	$61.32
Hawaii									
Idaho	X			X	X			$167.96	$58.91
Illinois	X	X			X	X	$72.00		
Indiana	X				X	X	$29.62	$42.04/hr	$18.31/hr
Iowa	X			X	X		$128.50	$117.79	$53.34
Kansas	X				X	X		$50.00	$40.50
Kentucky	X				X	X		$88.16	$34.13
Louisiana	X						$42.56		
Maine	X			X	X				
Maryland	X				X		$97.34	$120.76	$59.99
Massachusetts	X			X	X		$89.21	$64.84/hr	$24.40/hr
Michigan	X			X	X		$80.98	$80.98	$51.72
Minnesota	X								$57.57
Mississippi				X			$75.85		
Missouri	X			X	X		$77.16	$77.16	$77.16
Montana	X			X			$74.31	$74.31	$33.10
Nebraska	X	X	X		X			$36.57/hr	
Nevada	X				X		$64.08/hr		
New Hampshire	X				X			$87.36/hr	$23.56/hr
New Jersey	X	X		X	X		$41.83	$49.04	$38.28
New Mexico	X				X				
New York	X					X			
North Carolina	X				X		$109.60	$103.33	$47.28
North Dakota	X						$120.23	$54.00/hr	$120.23
Ohio	X			X	X			$47.40/hr	$23.57/hr
Oklahoma				X			$46.07	$63.41	$28.72
Oregon	X		X	X	X			$193.63	$53.59
Pennsylvania	X			X	X		$88.00		
Rhode Island	X				X	X	$67.18	$67.18	$22.26
South Carolina	X			X	X		$99.29		
South Dakota	X						$37.69	$58.72/hr	$27.40/hr
Tennessee	X			X	X				
Texas	X						$205.12	$98.92	$148.28/hr
Utah	X				X				$65.03
Vermont	X							$109.51	$49.44
Virginia	X			X	X			$180.02	$73.90
Washington	X				X		$59.99	$63.51	$55.32
West Virginia	X				X	X			
Wisconsin	X				X	X	$85.54	$32.69/hr	$40.31
Wyoming	X			X			$87.75	$130.00	$45.50
TOTAL:	**46**	**5**	**4**	**23**	**36**	**12**	**$81.88 average pay rate**	**$86.41 average pay rate**	**$47.28 average pay rate**

NOTE: *Optional therapy services include physical, occupational, and/or speech therapy.
SOURCE: KFF Medicaid State Plan Home Health Program Survey, FY 2017.

Appendix Table 3: State Policy Choices for Medicaid Personal Care State Plan Benefits, FY 2017											
State	Service Site, besides beneficiary home		Self-Dir.	Utilization Controls		Provider Type		Provider Criminal Background Checks	Provider Training	Provider Reimbursement Rates (per hour)	
	Work	Other Comm. Setting		Cost Cap	Hour Cap	Agency	Indep.			Agency	Provider
Alaska			X			X		X	X	$24.40	
Arkansas	X	X		NR	NR	NR	NR	NR	NR		
California	X		X		X	X	X	X	X		$14.00
Colorado	X	X	X			X		X		$19.28	
Delaware	NR	NR	NR	NR	NR	NR	NR	NR	NR		
DC	X	X			X	X		X	X	$20.08	
Florida		X				X	X	X	X	$15.00	$15.00
Idaho	X	X	X		X	X		X	X	$15.76	
Kansas	NR	NR	NR	NR	NR	NR	NR	NR	NR		
Louisiana	X				X	X		X	X	$11.40	
Maine		X	X			X	X	X	X	$20.12	
Maryland	X	X				X		X		$16.99	
Massachusetts	X	X	X		X		X		X		$16.52
Michigan	X		X			X	X	X		$14.25	$9.95
Minnesota	X	X	X		X	X		X	X	$17.40	
Missouri			X	X		X		X	X	$17.22	
Montana		X	X		X	X			X	$19.44	
Nebraska	X				X		X	X		$9.78	$9.78
Nevada			X		X	X		X	X	$17.00	
New Hampshire	X	X	X			X		X	X		
New Jersey	X	X	X		X	X	X	X	X	$41.83	$38.28
New Mexico	NR	NR	NR	NR	NR	NR	NR	NR	NR		
New York	X	X	X			X		X			
North Carolina					X	X		X	X	$15.60	
North Dakota	X	X			X	X	X			$37.10	$29.52
Oklahoma	X					X	X	X	X	$15.68	
Oregon			X		X	X	X	X		$22.32	$15.00
Rhode Island	X					X		X	X		
South Dakota	X	X			X	X		X	X	$37.38	
Texas	X	X	X			X	X	X		$13.22	$10.43
Utah	X	X	X			NR	NR	NR	NR	$19.08	$11.64
Vermont	X	X	X		X		X	X			
Washington	X	X	X			X	X	X	X	$26.32	$13.58
West Virginia	X	X			X	X		X	X	$16.00	
Wisconsin			X			X		X	X	$43.02	
TOTAL:	**23**	**20**	**20**	**1**	**16**	**26**	**13**	**27**	**21**	**$21.03 aver.**	**$16.70 aver.**
No Personal Care Program (16 states)											
Alabama											
Arizona											
Connecticut											
Georgia											
Hawaii											
Illinois											
Indiana											
Iowa											
Kentucky											
Mississippi											
Ohio											
Pennsylvania											
South Carolina											
Tennessee											
Virginia											
Wyoming											

NOTE: NR = no response.
SOURCE: KFF Medicaid State Plan Personal Care Program Survey, FY 2017.

Appendix Table 4: State Section 1915 (c) HCBS Waivers by Target Population, FY 2017									
State	Total Number of Waivers	Population Served							
		I/DD	Seniors	Seniors & Adults with Physical Disabilities	Adults with Physical Disabilities	Med. Fragile/ Tech Dep. Children	HIV/ AIDS	Mental Health	TBI/ SCI
Alabama	7	X		X	X		X		
Alaska	4	X		X		X			
Arkansas	4	X		X					
California	8	X	X	X	X	X	X		
Colorado	11	X		X		X		X	X
Connecticut	10	X	X		X	X		X	X
Delaware	1	X							
DC	2	X		X					
Florida	7	X		X		X	X		X
Georgia	5	X		X	X			X	
Hawaii	1	X							
Idaho	4	X		X					
Illinois	9	X	X	X	X	X	X		X
Indiana	4	X		X					X
Iowa	7	X	X		X		X	X	X
Kansas	7	X	X		X	X		X	X
Kentucky	6	X		X		X			X
Louisiana	7	X		X				X	
Maine	5	X		X					X
Maryland	6	X		X		X			X
Massachusetts	10	X	X	X					X
Michigan	4	X		X				X	
Minnesota	5	X	X		X				X
Mississippi	5	X		X	X				X
Missouri	10	X		X	X		X		
Montana	4	X		X				X	
Nebraska	5	X		X					X
Nevada	3	X	X		X				
New Hampshire	4	X		X					X
New Jersey	1	X							
New Mexico	3	X							
New York	10	X		X		X		X	X
North Carolina	3	X		X		X			
North Dakota	6	X		X	X	X			
Ohio	8	X		X	X				
Oklahoma	6	X		X	X				
Oregon	6	X		X		X			
Pennsylvania	9	X		X	X				X
South Carolina	8	X		X	X	X	X		X
South Dakota	4	X		X					X
Tennessee	3	X							
Texas	6	X				X		X	
Utah	8	X	X	X	X	X			X
Virginia	7	X		X	X				
Washington	8	X		X					
West Virginia	3	X		X					X
Wisconsin	7	X		X				X	
Wyoming	5	X		X				X	X
TOTAL:	**276 waivers**	**48 states**	**9 states**	**37 states**	**18 states**	**16 states**	**7 states**	**12 states**	**22 states**
No Section 1915 (c) Waivers (3 states)									
Arizona									
Rhode Island									
Vermont									

NOTES: I/DD = intellectual and developmental disabilities. TBI = traumatic brain injury. SCI = spinal cord injury. States may offer more than one Section 1915 (c) waiver per target population category. Other states may serve these populations through Section 1115 waivers.
SOURCE: KFF Medicaid HCBS Waiver Survey, FY 2017.

Appendix Table 5: State Section 1115 HCBS Waivers by Target Population, FY 2017								
State	Total Number of Waivers	Population Served						
		I/DD	Seniors	Adults with Physical Disabilities	Med. Fragile/ Tech Dep. Children	HIV/ AIDS	Mental Health	TBI/ SCI
Arizona	1	X	X	X				
California	1		X	X				
Delaware	1		X	X		X	X	X
Hawaii	1		X	X	X	X		
New Jersey	1		X	X				X
New Mexico	1		X	X				
New York	1	X	X	X				
Rhode Island	1	X	X	X	X	X	X	X
Tennessee	1	X	X	X				
Texas	1		X	X				
Vermont	1	X	X	X				
TOTAL:	**11**	**5**	**11**	**11**	**2**	**3**	**2**	**3**
No Stand-Alone Section 1115 HCBS Waivers (40 states)								
Alabama								
Alaska								
Arkansas								
Colorado								
Connecticut								
DC								
Florida								
Georgia								
Idaho								
Illinois								
Indiana								
Iowa								
Kansas**								
Kentucky								
Louisiana								
Maine								
Maryland								
Massachusetts								
Michigan								
Minnesota								
Mississippi								
Missouri								
Montana								
Nebraska								
Nevada								
New Hampshire								
North Carolina								
North Dakota								
Ohio								
Oklahoma								
Oregon								
Pennsylvania								
South Carolina								
South Dakota								
Utah								
Virginia								
Washington								
West Virginia								
Wisconsin								
Wyoming								
NOTES: I/DD = intellectual and developmental disabilities. TBI = traumatic brain injury. SCI = spinal cord injury. Other states serve these populations through Section 1915 (c) waivers. **KS has joint § 1115/1915 (c) waivers. SOURCE: KFF Medicaid HCBS Waiver Survey, FY 2017.								

Appendix Table 6: State Financial Eligibility Criteria for Medicaid HCBS Waivers by Target Population, FY 2017								
	I/DD	Seniors	Seniors & Adults with Physical Disabilities	Adults with Physical Disabilities	Med. Fragile/ Tech Dep. Children	HIV/ AIDS	Mental Health	TBI/ SCI
Eligibility Limit as a % of SSI, unless otherwise noted								
Alabama	300%		300%	300%		300%		
Alaska	300%		300%		300%			
Arizona	300%		300%					
Arkansas	300%		300%					
California	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL		
Colorado	300%		300%		300%		300%	300%
Connecticut	300%	300%		300%	300%		300%	300%
Delaware	250%	250%	250%	250%		250%	250%	250%
DC	300%		300%					
Florida	300%		300%		300%	300%		300%
Georgia	300%		300%	300%			300%	
Hawaii	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL		
Idaho	300%		300%					
Illinois	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL	100% FPL		100% FPL
Indiana	300%		300%					300%
Iowa	300%	300%		300%		300%	300%	300%
Kansas	300%	300%		300%	300%		300%	300%
Kentucky	300%		300%		300%			300%
Louisiana	300%		300%				300%	
Maine	300%		300%					300%
Maryland	300%		300%		300%			300%
Massachusetts	300%	300%	300%					300%
Michigan	100% FPL		300%				300%	
Minnesota	95% FPL	300%		95% FPL				95% FPL
Mississippi	300%		300%	300%				300%
Missouri	100%		170%	100%		100%		
Montana	100%		100%				100%	
Nebraska	100%		100% FPL					100% FPL
Nevada	300%	300%		300%				
New Hampshire	300%		300%					300%
New Jersey	300%		300%			300%		
New Mexico	300%		300%	300%				
New York	100% FPL		84% FPL		100% FPL		100% FPL	100% FPL
North Carolina	100% FPL		100%		100%			
North Dakota	100%		100%	100%	100%			
Ohio	300%		300%	300%				
Oklahoma	300%		300%	300%				
Oregon	300%		300%		300%			
Pennsylvania	300%		300%	300%				300%
Rhode Island	300%	300%	300%	300%	300%	300%	300%	300%
South Carolina	100% FPL		300%	300%	300%	300%		300%
South Dakota	300%		300%					300%
Tennessee	300%	300%	300%	300%				
Texas	300%		300%		300%		300%	
Utah	300%	300%	300%	300%	300%			300%
Vermont	300%		300%					300%
Virginia	300%		300%	300%				
Washington	300%		300%					
West Virginia	300%		300%					300%
Wisconsin	300%		300%				300%	
Wyoming	300%		300%				300%	300%

NOTES: I/DD = intellectual and developmental disabilities. TBI = traumatic brain injury. SCI = spinal cord injury. Data include § 1915 (c) and § 1115 waivers. States may offer more than one § 1915 (c) waiver per target population category. Blank cell indicates state does not cover that population.
SOURCE: KFF Medicaid HCBS Program Surveys, FY 2017.

Appendix Table 7: State HCBS Waiver Self-Direction Policy Choices, FY 2017									
State	Self-Direction Allowed	Agency-Employed Providers				Independent Providers			
		Select/ Dismiss Worker	Set Worker Schedule	Set Worker Pay	Allocate Service Budget	Select/ Dismiss Worker	Set Worker Schedule	Set Worker Pay	Allocate Service Budget
Alabama	X	X	X	X		X	X	X	X
Alaska									
Arizona	X	X	X			X	X		
Arkansas									
California	X*	X	X			X	X		
Colorado	X*	X	X			X	X	X	X
Connecticut	X*	X	X	X	X	X	X	X	X
Delaware	X*	Agency providers not covered				X	X		
DC	X	X	X	X	X	Independent providers not covered			
Florida	X*	X	X		X	X	X		X
Georgia	X	Agency providers not covered				X	X	X	X
Hawaii	X*	Agency providers not covered				X	X	X	
Idaho	X	X	X			X	X	X	X
Illinois	X*	X	X		X	X	X		
Indiana	X	Agency providers not covered				X	X		
Iowa	X*	Agency providers not covered				X	X	X	X
Kansas	X	X	X			X	X		
Kentucky	X*				X	X	X	X	X
Louisiana	X*	Agency providers not covered				X	X	X	X
Maine	X	X	X		X	X	X		X
Maryland	X*	X	X	X	X	Independent providers not covered			
Massachusetts	X*	X	X	X	X	X	X	X	X
Michigan	X	X	X	X	X	X	X	X	X
Minnesota	X*	X	X	X	X	X	X	X	X
Mississippi**	X*	Agency providers not covered				X	X		
Missouri	X	X	X			X	X	X	X
Montana	X*	X	X		X	X	X	X	X
Nebraska	X*	X	X			X	X	X	X
Nevada									
New Hampshire	X*	X	X	X	X	X	X	X	X
New Jersey	X*	X	X	X	X	X	X	X	X
New Mexico	X*	X	X	X	X	X	X	X	X
New York	X		X		X	X	X	X	X
North Carolina	X*		X			X	X	X	X
North Dakota	X*	X	X	X		X	X	X	X
Ohio	X*	X	X	X	X	X	X	X	X
Oklahoma	X*	Agency providers not covered				X	X	X	X
Oregon	X	Agency providers not covered				X	X		X
Pennsylvania	X*	X	X	X		X	X	X	X
Rhode Island	X	Agency providers not covered				X	X	X	X
South Carolina	X*	X	X			X	X		
South Dakota	X*	X	X	X	X	Independent providers not covered			
Tennessee	X*	Agency providers not covered				X	X	X	X
Texas	X*	X	X			X	X	X	X
Utah	X*	Agency providers not covered				X	X	X	
Vermont	X*	Agency providers not covered				X	X	X	X
Virginia	X*	Agency providers not covered				X	X		
Washington	X*	X	X		X	X	X		X
West Virginia	X*	X	X	X	X	Independent providers not covered			
Wisconsin	X*	X	X	X	X	X	X	X	X
Wyoming	X*	Agency providers not covered				X	X	X	X
TOTAL:	**48**	**30**	**32**	**16**	**20**	**44**	**44**	**31**	**32**

NOTES: HCBS waivers include § 1915 (c) and § 1115. *Denotes family members can be paid as independent providers. **Self-direction not available statewide in MS.
SOURCE: KFF Medicaid HCBS Program Survey, FY 2017.

Appendix Table 8: State HCBS Waiver Utilization Control, Quality Measure and Ombuds Policy Choices, FY 2017								
State	Utilization Controls			Quality Measures			Ombuds Programs	
	Cost Cap	Hour Cap	Geo. Limit	Quality of Life	Community Integration	LTSS Rebalancing	Within State Government	Outside State Government
Alabama	X			X	X	X		
Alaska		X		X	X		X	
Arizona	X			X			X	
Arkansas				X			X	
California	X	X	X	X	X		X	
Colorado	X		X	X	X		X	
Connecticut	X			X	X		X	
Delaware	X			X	X	X	X	
DC		X		X			X	
Florida	X			X	X	X	X	
Georgia				X		X	X	
Hawaii				X	X	X		X
Idaho	X	X		X	X	X		
Illinois	X			X	X		X	
Indiana	X			X			X	
Iowa	X	X		X	X	X	X	
Kansas	X			X	X	X	X	
Kentucky	X	X		X	X		X	
Louisiana	X	X		X	X		X	X
Maine	X			X	X	X	NR	
Maryland	X	X		X	X		NR	
Massachusetts	X	X		X	X	X	X	
Michigan		X		X	X			X
Minnesota	X		X	X	X	X	X	
Mississippi				X	X		X	X
Missouri	X	X					NR	
Montana	X			X	X		X	
Nebraska		X		X	X		X	
Nevada				X	X		X	
New Hampshire	X			X	X		X	
New Jersey	X			X	X	X	NR	
New Mexico	X	X			X		X	X
New York	X		X	X	X			X
North Carolina	X	X		X	X		NR	
North Dakota	X			X	X		X	
Ohio	X			X	X		X	
Oklahoma	X	X		X	X		X	
Oregon				X	X		X	
Pennsylvania	X			X			X	
Rhode Island	X			X	X	X		X
South Carolina	X	X		X			X	
South Dakota	X	X		X	X		X	
Tennessee	X			X	X	X		X
Texas	X	X		X	X		X	
Utah							X	
Vermont				X	X	X		X
Virginia				X	X		NR	
Washington	X			X	X		X	X
West Virginia	X	X		X	X		X	
Wisconsin				X	X	X	X	X
Wyoming	X	X		X	X	X	X	X
TOTAL:	**37**	**20**	**4**	**48**	**42**	**17**	**37**	**12**

NOTE: HCBS waivers include § 1915 (c) and § 1115. NR indicates state did not respond to question.
SOURCE: KFF Medicaid HCBS Program Survey, FY 2017.

Appendix Table 9: State MLTSS Policy Choices, FY 2017					
State	LTSS Provider Network Adequacy Standards	Independent Enrollment Options Counseling	Disenrollment if LTSS Provider Leaves Plan Network	Stakeholder Advisory Committee	
				State-Level	Health Plan Level
Arizona	X		X	X	X
California	X	X		X	X
Delaware	X	X	X	X	X
Florida	X	X	X	X	X
Hawaii	X			X	X
Idaho			X		X
Illinois	X	X		X	X
Iowa	X	X	X	X	X
Kansas	X	X	X	X	X
Massachusetts					
Michigan	X		X	X	X
Minnesota		X		X	X
New Jersey	X	X		X	X
New Mexico		X	X	X	X
New York		X	X	X	
North Carolina				X	
Ohio	X	X	X	X	X
Rhode Island		X	X	X	X
South Carolina					
Tennessee	X	X	X	X	X
Texas	X	X	X	X	X
Vermont		X		X	
Virginia		X			
Wisconsin	X	X	X	X	X
TOTAL:	14	17	14	20	18
No MLTSS Program in 2017 (26 states):					
Alabama					
Alaska					
Arkansas*					
Colorado					
Connecticut					
DC					
Georgia					
Indiana					
Kentucky					
Louisiana					
Maine					
Maryland					
Mississippi					
Missouri					
Montana					
Nebraska					
Nevada					
New Hampshire					
North Dakota					
Oklahoma					
Oregon					
Pennsylvania*					
South Dakota					
Utah					
Washington					
West Virginia					
Wyoming					
NOTES: *PA's § 1915 (b)/(c) waiver was approved in Feb. 2018. AR's § 1915 (b)/(c) waiver was approved in Jan. 2019. SOURCE: KFF Medicaid HCBS Program Survey, FY 2017.					

Appendix Table 10: State Policy Choices About HCBS Settings Rule, FY 2017					
State	State Rule/Policy Change Needed	Settings Must Be Modified	Settings Cannot Be Modified	Plan To Submit Information to Overcome Institutional Presumption	Settings Presumed Institutional Because Effectively Isolate Beneficiaries
Alabama	X	X (3)		X (1)	X (2)
Alaska	X				
Arizona	X	X (7)	X (5)		
Arkansas		X (TBD)		X (17)	X (TBD)
California	X			X	X
Colorado	X	X (3)		X	X
Connecticut	X	X (50)		X (4)	
Delaware	X	X (460)	X (1)	X (1)	
DC	X	X			
Florida		X (TBD)	X (TBD)	X (TBD)	X (TBD)
Georgia	X				
Hawaii	X	X (1,368)		X (1)	X (1)
Idaho	X	X (97)		X	X (121)
Illinois	X	X (5)		X	
Indiana	X	X (TBD)		X	X (TBD)
Iowa	X	X (1)		X (5)	X (3)
Kansas	NR				
Kentucky	X	X		X	X
Louisiana	X		X (4)	X (1)	
Maine	NR				
Maryland	X	X (TBD)		X (5)	
Massachusetts	NR				
Michigan	X	X (900)		X (35)	X (TBD)
Minnesota	X			X (135)	
Mississippi	X	X			
Missouri	X	X (35)		X (21)	
Montana	X	X (294)		X (16)	
Nebraska	X	X (TBD)	X (1)	X (60)	X (TBD)
Nevada	X			X (TBD)	X (1)
New Hampshire	X	X		X (5)	X (66)
New Jersey	X	X			
New Mexico	X				
New York	X	X (522)		X (189)	X (215)
North Carolina	X	X	X (20)		
North Dakota	X				
Ohio	X	X (342)	X (TBD)	X (70)	X
Oklahoma	X	X		X (2)	
Oregon	X	X (946)	X	X (5)	X (5)
Pennsylvania	X				
Rhode Island	X	X (TBD)	X (2)	X (12)	X (3)
South Carolina	X	X (1,122)		X	X (TBD)
South Dakota	X	X (25)		X (43)	X (10)
Tennessee	X	X (189)	X (23)	X (TBD)	X (TBD)
Texas	X	X (TBD)			
Utah	X				
Vermont	X				
Virginia	X	X (TBD)		X	X (TBD)
Washington	X		X (8)		
West Virginia		X (1)			
Wisconsin	X	X (TBD)		X (TBD)	X, TBD
Wyoming	X	X (2)			
TOTAL:	**45**	**36**	**11**	**32**	**23**

NOTES: NR indicates state did not respond to question. Numbers in parentheses indicate number of settings. TBD indicates number of settings to be determined.
SOURCE: KFF Medicaid HCBS Program Survey, FY 2017.

Appendix Table 11: State Policy Choices About Direct Care Worker Minimum Wage and Overtime, 2015-2017												
State	Plan To Restrict Worker Hours or Make Other Policy Change			Limit Worker Hours to 40 hours/week			Budget State Funds for Worker Overtime Pay			Budget State Funds for Worker Travel Time Pay		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Alabama								X	X		X	X
Alaska												
Arizona												
Arkansas												
California	X	X	X				X	X	X	X	X	X
Colorado												
Connecticut							X		X	X		X
Delaware		X										
DC												
Florida												
Georgia		X										
Hawaii		X										
Idaho												
Illinois								X	X		X	X
Indiana												
Iowa		X	X		X	X						
Kansas		X	X									
Kentucky	X	X	X				X	X	X			
Louisiana												
Maine	X		X	X		X						
Maryland	X											
Massachusetts								X	X		X	X
Michigan												
Minnesota												
Mississippi									X			X
Missouri												
Montana												
Nebraska								X	X		X	X
Nevada												
New Hampshire		X	X									
New Jersey												
New Mexico	X	X	X	X	X	X						
New York												
North Carolina												
North Dakota			X									
Ohio			X									
Oklahoma		X	X		X	X						
Oregon	X	X	X	X*	X*		X		X	X		X
Pennsylvania							X	X	X			
Rhode Island												
South Carolina							X	X	X	X	X	X
South Dakota												
Tennessee		X										
Texas												
Utah												
Vermont												
Virginia			X									
Washington	X	X	X	X*	X*		X	X	X	X	X	X
West Virginia												
Wisconsin		X	X		X	X		X	X			
Wyoming		X	X		X	X						
TOTAL:	7	15	15	4	7	6	7	10	13	5	7	10

NOTES: *50 hour limit in Oregon for some providers; independent respite care providers are limited to 65 hours in Washington.
SOURCE: KFF Medicaid HCBS Program Surveys, FY 2015-2017.

Endnotes

[1] For additional background, *see* Kaiser Family Foundation, *Streamlining Medicaid Home and Community-Based Services: Key Policy Questions* (March 2016), https://www.kff.org/medicaid/issue-brief/streamlining-medicaid-home-and-community-based-services-key-policy-questions/; Kaiser Family Foundation, *Medicaid Long-Term Services and Supports: An Overview of Funding Authorities* (Sept. 2013), http://kff.org/medicaid/fact-sheet/medicaid-long-term-services-and-supports-an-overview-of-funding-authorities/.

[2] The remaining seven states did not specify home health provider training requirements.

[3] The average includes 34 states that reported a per visit agency reimbursement rate and three states that reported a per hour agency reimbursement rate.

[4] The average includes 15 states that reported per visit direct payment or mandated rates for registered nurses and eight states that reported per hour rates for registered nurses.

[5] The average includes 22 states that reported per visit direct payment or mandated rates for home health aides and 10 states that reported per hour rates.

[6] Three states (DE, KS, and NM) have CMS approval to offer personal care state plan services but deliver those services through Section 1115 capitated managed care waivers. These states did not separately report personal care state plan enrollment and spending and did not complete the policy survey.

[7] The state that does not cover assistance with household activities (Idaho) instead provides cueing or monitoring and tasks delegated by a nurse.

[8] CO newly began reporting coverage of personal care services in 2017; its benefit is limited to children up to age 21 under EPSDT.

[9] KS reported that it allowed self-direction in 2016, but did not respond to the personal care policy survey for 2017.

[10] Twenty-five states reported agency reimbursement rates.

[11] Eleven states reported direct payment or mandated provider reimbursement rates.

[12] CFC services includes hands-on assistance, supervision or cueing and services for the acquisition, maintenance, and enhancement of skills necessary for individuals to accomplish self-care, household activity, and health-related tasks. Health-related tasks are those that can be delegated by a licensed health care professional to be performed by an attendant.

[13] Backup systems include electronic devices to ensure continuity of services as well as individuals identified by the beneficiary.

[14] Transition costs may include rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other required necessities.

[15] These services may be covered to the extent that expenditures otherwise would be made for human assistance.

[16] Two states (CA and NY) did not respond to this question.

[17] NY did not respond to the CFC portion of the survey. Data supplemented from NY State Plan Amendment #13-0035, approved by CMS Oct. 23, 2015, https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/NY-13-0035.pdf.

[18] Texas only applies this rule to individuals enrolled in its Section 1915 (c) waivers; this rule does not apply to individuals who are eligible for Medicaid under the expanded financial eligibility rules (217-group) in Texas's Section 1115 HCBS waiver.

[19] This option specifically applies to the 217 HCBS waiver group, individuals for whom the state has opted to expand the minimum Medicaid HCBS financial eligibility limit under the "special income rule" (up to a federal maximum of 300% SSI), who would be eligible under the Medicaid state plan if institutionalized, meet an institutional level of care, and would be institutionalized if not receiving waiver services. These individuals must be receiving at least one waiver service per month to qualify for CFC services.

[20] 42 C.F.R. § 441.510 (a), (b).

[21] 42 C.F.R. § 441.510 (d).

[22] Two states (ID and IN) offer more than one Section 1915 (c) benefit. These states target the same general population (people with I/DD in ID, and people with mental illness in IN) but offer different benefit packages based on age.

[23] Indiana offers Section 1915 (i) services targeted to multiple populations with mental illness (differentiated by age) and uses Section 1915 (i) as an independent pathway to Medicaid eligibility for one of these populations.

[24] Kansas is excluded from this list because it has joint Section 1115/1915 (c) HCBS waivers.

[25] Some of these waivers include both populations, while others target one of the two populations.

[26] In addition, while it does not have eligibility criteria specific to people with TBI, distinct from the criteria for adults with physical disabilities, the benefit package in NJ's Section 1115 waiver includes services targeted to people with TBI.

[27] States also may cover children with significant disabilities under the Katie Beckett/TEFRA state plan option.

[28] Some states apply different policies to agency-employed vs. independent providers.

[29] Some states apply different policies to agency-employed vs. independent providers.

[30] Some states apply different policies to agency-employed vs. independent providers.

[31] A major way that states control waiver enrollment, and therefore costs, are enrollment caps, which may result in waiting lists; these policies are discussed in Kaiser Family Foundation, *Key Questions About Medicaid Home and Community-Based Services Waiver Waiting Lists* (April 2019), https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-servcies-waiver-waiting-lists. .

[32] These utilization controls are state policies, separate from the federal cost neutrality requirement for HCBS waivers. Under federal law, the state's estimated average per capita expenditures for home and community-based waiver services must not exceed the state's reasonable estimate of the cost of average per capita expenditures that would have been incurred without waiver services. 42 U.S.C. § 1396n (c)(2)(D). In addition, under long-standing federal policy, all Section 1115 waivers also are subject to federal budget neutrality, which requires that federal costs under the waiver cannot exceed estimated costs without the waiver.

[33] Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[34] Twelve states (Colorado, Indiana, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, Ohio, Oregon, Pennsylvania, and Tennessee) participated in the NCI-AD survey data in 2016-2017. Measures related to quality of life include: proportion of people who are able to participate in preferred activities outside of home when and with whom they want; proportion of people who are involved in making decisions about their everyday lives (where they live, what they do during the day, staff that supports them, with whom they spend time); proportion of people who are able to see or talk to friends and families when they want; proportion of people who are not lonely; proportion of people who are satisfied with where they live; proportion of people who are satisfied with what they do during the day; proportion of people who are satisfied with staff who work with them; proportion of people who feel in control of their lives. Nat'l Assoc. of State United for Aging and Disabilities and Human Servs. Research Institute, *National Core Indicators – Aging and Disability Adult Consumer Survey 2016-2017 National Results*, https://nci-ad.org/upload/reports/NCI-AD_2016-2017_National_Report_FINAL.pdf.

[35] Examples of community integration measures include how often in the last three months you could get together with family who live nearby when you wanted to; how often in the last three months you could get together with friends who live nearby when you wanted to; how often in the last three months you could do things in the community that you like; did you need more help than you get from personal assistance or behavioral health staff to do things in your community in the last three months; did you take party in deciding what you do with your time each day in the last three months; did you take part in deciding when you do things each day (get up, eat, go to bed) in the last three months. Medicaid.gov, *CAHPS Home and Community-Based Services Survey* (accessed Jan. 22, 2019), https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html.

[36] Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[37] Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/. The revised regulations build on and incorporate elements from CMS's May 2013 best practices for MLTSS waivers. CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs* (May 2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

[38] For a summary of the proposed changes, *see* Kaiser Family Foundation, *CMS's 2018 Proposed Medicaid Managed Care Rule: A Summary of Major Provisions* (Jan. 2019), https://www.kff.org/medicaid/issue-brief/cmss-2018-proposed-medicaid-managed-care-rule-a-summary-of-major-provisions/.

[39] The informational bulletin indicates that the "use of enforcement discretion will be applied based on state-specific facts and circumstances and focused on states' specific needs." CMS Informational Bulletin, *Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates* (June 30, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf.

[40] *Id.*

[41] The November 2018 proposed rule would change the general network adequacy requirement for time and distance standards for certain provider types as well as the specific requirement for time and distance standards for LTSS providers to whom enrollees must travel. Kaiser Family Foundation, *CMS's 2018 Proposed Medicaid Managed Care Rule: A Summary of Major Provisions* (Jan. 2019), https://www.kff.org/medicaid/issue-brief/cmss-2018-proposed-medicaid-managed-care-rule-a-summary-of-major-provisions/.

[42] Along with personalized choice counseling, the beneficiary support system must include assistance to beneficiaries with understanding managed care and assistance for enrollees who use or wish to use LTSS. Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[43] *Id.*

[44] Kaiser Family Foundation, *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions* (June 2016), https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[45] 42 C.F.R. § 441.301 (c)(4)-(6). In addition to Section 1915 (c) waiver HCBS, the settings rule also applies to Section 1915 (i) and Community First Choice services. CMS also has indicated that it will include the setting rule requirements in the special terms and conditions of Section 1115 waivers that include HCBS. CMS, *Questions and Answers – 1915 (i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915 (c) Home and Community-Based Services Waivers – CMS 2249-F and 2296-F,* https://www.medicaid.gov/medicaid/hcbs/downloads/final-q-and-a.pdf.

[46] CMCS Informational Bulletin, *Extension of Transition Period for Compliance with Home and Community-Based Settings Criteria* (May 9, 2017), https://www.medicaid.gov/federal-policy-guidance/downloads/cib050917.pdf.

[47] Medicaid.gov, *Statewide Transition Plans* (accessed March 27, 2019), https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html.

[48] These states are AL, AZ, CA, CT, GA, HI, IN, IA, LA, MD, MI, MS, MO, MT, NE, NH, NM, NC, NY, OH, PA, RI, SC, SD, UT, VT, VA, WV, and WI. The nine remaining states are in "clarifications and/or modifications required for initial approval status" (CO, FL, IL, KS, MA, ME, NJ, NV, TX). *Id.*

[49] CMS recently released guidance on the heightened scrutiny process. CMS, SMD #19-001, *Home and Community-Based Settings Regulation – Heightened Scrutiny* (March 22, 2019), https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf.

[50] U.S. Dep't of Labor, Home Care, *Minimum Wage and Overtime Pay for Direct Care Workers* (accessed Jan. 22, 2019), https://www.dol.gov/whd/homecare/; 29 C.F.R. § § 552.3, 552.6, 552.101, 552.102, 552.106, 552.109, 552.110.

[51] Specifically, CMS anticipated that "many states will determine that, for purposes of the FLSA, home care workers in self-direction programs have joint third party employer(s) [such as the state or another entity] in addition to being employed by the beneficiary," requiring the state or other entity to comply with minimum wage and overtime requirements. CMS Informational Bulletin, *Self-Direction Program Options for Medicaid Payments in the Implementation of the Fair Labor Standards Act Regulation Changes* (July 3, 2014), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-03-2014.pdf.

[52] Applies to individual providers (IPs) of respite care. If IPs provided more than 40 hours of services per week in January 2016, they may continue to work these overtime hours up to 65 hours per week; if IPs worked 40 hours or less per week during January 2016, they are restricted to 40 hours per week.