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Home and Community-Based Services for Older Adults: Medicaid Waivers

The Medicaid program is the major source of financing for long-term care, providing services for low-income individuals or those that become low-income as a result of paying for long-term care or medical needs. While Medicaid long-term care expenditures are still predominantly institutional, with nearly 70 percent of long-term care expenditures going to nursing homes and other institutional settings, there has been a growing trend toward home and community-based services that started with the implementation of the Medicaid Waiver program in 1981. The use of Medicaid waivers as an effective means of reducing long-term costs was highlighted in a recent study by the Assistant Secretary for Planning and Evaluation with the U.S. Department of Health and Human Services, which found that the annual cost for providing care for an individual under the waiver program is $5,820 compared to $29,112 for nursing home care.

Issue Background

Medicaid waivers are often an essential element in the establishment of comprehensive and coordinated service delivery systems for older adults that offer a broad range of choice of home and community-based long-term care services along with institutional care. Furthermore, the need to comply with the *Olmstead v. L.C.* Supreme Court decision to avoid inappropriate institutional care provides an additional impetus for expansion of Medicaid waivers to foster development of a wide range of home and community-based care options.

Sections 1915 (program waivers) and 1115 (research and demonstration waivers) of the Social Security Act allow states to apply to the federal government to obtain exemptions from certain Medicaid statutes. The 1915 (c) waiver is most relevant to home and community-based services because it allows services to be provided to certain recipients at home or in other community-based settings rather than in institutional or long-term care facilities. The categories of eligible populations include the elderly, disabled, mentally ill and people with specific illnesses or conditions.

The waiver typically allows states to overcome statewide and comparability requirements. Also, the 1915 (c) waiver often includes a request not to apply the same income eligibility requirements throughout the state. The 1915 (c) waivers allow states to provide services beyond the scope of traditional Medicaid benefits to cover additional medical and non-medical services, including home health, case management, personal care, homemaker, adult day health, rehabilitation, and respite care. In addition, other services such as in-home support, transportation, and environmental modifications may be included if the state demonstrates they are necessary in order to avoid institutionalization.

The purpose of the 1115 waiver is "to experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of Medicaid." 1115 waivers can be used to waive a much broader set of Medicaid requirements than 1915 (c) waivers as long as program changes do not create additional federal costs or are budget neutral. These waivers typically permit states to expand eligibility or benefit packages by generating savings and reinvesting the savings into program expansion.

Proposed 1115 waiver programs must include a research component that provides new information on models that adapt Medicaid to specific state needs. Also, the proposed benefit package must not be less than the full coverage currently offered in the state.

Waiver Process

Medicaid waivers must demonstrate cost-effectiveness or budget neutrality. Proposed changes under a waiver request cannot cost the federal government more than the expected Medicaid costs for the traditional Medicaid program under the same time period. The Office of Management and Budget must determine that 1915 waivers are cost-effective and that 1115 waiver requests are budget neutral.

The evaluation of the cost effectiveness and budget neutrality of Medicaid waiver proposals should take into consideration potential cost savings not only for Medicaid but also for Medicare, Supplemental Security Insurance, and Social Security Disability Insurance. The current lack of coordination between Medicare and Medicaid exacerbates the fragmentation of acute and long-term care.

Policy Recommendations

Medicaid waivers will continue to play a critical role in the ability of states to develop comprehensive and coordinated service delivery systems for older adults that offer a broad range of home and community-based long-term care services. While Medicaid spending for home and community-based services is increasing, policymakers must work to make requirements less restrictive and Medicaid dollars more available to the states as the demand for home and community-based care continues to grow.

n4a urges policymakers to:

- **Increase the federal Medicaid match to states by 3% and dedicate the resulting savings in long-term care funds to home and community-based services;**
- **Reduce barriers for states and federally recognized Indian tribes to implement additional 1915 (c) waivers so they may offer increasing alternatives to institutional care for individuals with long-term care needs;**
- **Reduce categorical funding barriers and support efforts to partner Medicaid waivers with other local, state, and federally assisted programs such as Older Americans Act services, federal housing programs, and community mental health services that provide home and community-based care;**
- **Promote greater coordination between the Medicare and Medicaid programs to address the interaction of acute and chronic care needs as a means of avoiding unnecessary hospitalization;**
- **Encourage approval of waiver proposals that integrate care for persons eligible for both Medicaid and Medicare; and**
- **Make financial incentives available from Medicare for Medicaid home and community-based long-term care providers who provide services that help reduce Medicare costs for dually- eligible consumers.**