

Medicaid Eligibility Policy Creates an Institutional Bias

Long-standing Medicaid eligibility policy creates a bias toward institutional care, making it difficult for individuals to remain in their home when they have long-term services and supports (LTSS) needs. This is particularly true among the aged and physically disabled population, as well as individuals with behavioral health needs (see chart below).

What are Home and Community-Based Services (HCBS)?

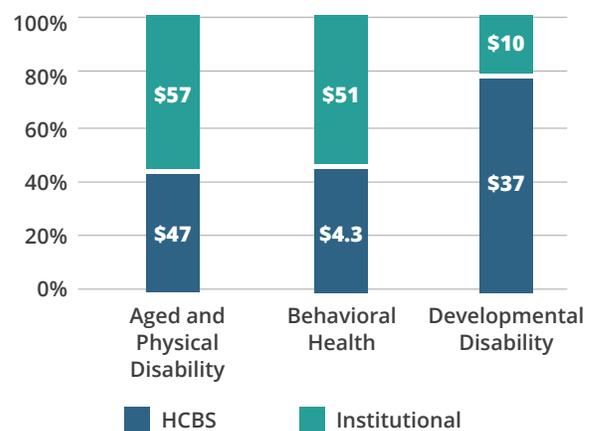
HCBS include a range of services that help a person live and thrive in the community. They include, but are not limited to homemaker, home health aide, personal care, adult day health, non-medical transportation, and employment supports.

Did you know?

An individual can qualify for Medicaid coverage if medical costs cause the person to spend down to a state-set income level, called the “medically needy” threshold. This threshold **cannot exceed 133% of a state’s Temporary Assistance for Needy Families (TANF) eligibility** and goes as low as 10% federal poverty level (FPL). It also **must be the same** for all covered groups, preventing a state from using this eligibility pathway to target HCBS programs to those most in need.

Individuals in the community with LTSS needs are allowed to retain a certain level of their own personal funds via a “personal needs allowance” (PNA) to pay for basic living such as rent and food. The PNA must meet a “reasonable assessment of need,” **but no minimum PNA is required**, and states may set the allowance too low to cover these costs (e.g., \$100 in some states).

2016 LTSS Spend by Population
(in billions)



Source for LTSS Spend: Eiken et al. *LTSS Expenditure Report 2016*. Published May 2018.

A 1915(c) waiver is the most common tool states use to cover HCBS. However, to qualify for a 1915(c) waiver slot, an individual must **already meet a state’s criteria for institutional care**. Further, **federal law excludes Institutes for Mental Disease (IMD) from the list of facility types that qualify as institutional care**. This prevents a state from using 1915(c) authority to meet HCBS needs of certain individuals with mental illness, or to address individuals before they escalate to full institutional need.

Among states with HCBS waiting list policies, **nearly half of the waivers provide services on a first come, first serve basis** without regard for priority of need.

Policymakers Can Help Reduce Institutional Bias Through Modernizing Medicaid and HCBS Eligibility Policy

Several eligibility policy options could increase access to HCBS and help ensure individuals have access to LTSS in the most appropriate setting of care.

Congress should consider a federal functional and financial eligibility “floor” and decouple medically needy eligibility from state TANF levels



Variation across state HCBS functional and financial eligibility criteria creates inequity and exacerbates unmet need. A federal eligibility floor, below which states are not permitted to implement waitlists, could reduce disparities in access. At a minimum, medically needy eligibility should not be limited to a state’s TANF eligibility level.

The Centers for Medicare & Medicaid Services (CMS) should implement a minimum personal needs allowance



State personal needs allowances for individuals should reflect costs of living in the home or community with dignity. CMS should define what is considered a “reasonable assessment of need.”

CMS should require states to remove home repairs from income and asset calculations



A reasonable value of home repairs should be permitted to help an individual to remain safely in the home. The cost of these home repairs should be excluded from income and asset calculations for purposes of Medicaid or HCBS eligibility.

CMS should encourage states to prioritize waitlists based on an individual’s level of need



An individual’s level of need and existing support infrastructure should be considered in prioritizing movement from HCBS waitlists to HCBS eligibility, to maximize the impact of available services.

Congress should allow Institutes for Mental Disease (IMD) to count as an institution for purposes of qualifying as Institutional Level of Care (ILOC) for 1915(c) programs



States should not be disincentivized from offering 1915(c) services and programs to individuals with mental health needs. Individuals residing in an IMD should be considered as meeting ILOC for purposes of qualifying for 1915(c) waivers.