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NARROWING MEDICAID'S LTC COVERAGE? THE IMPLICATIONS OF THE DRA'S HOME AND COMMUNITY-BASED CARE BENEFIT

Gene Coffey*

The Deficit Reduction Act of 2005 (DRA)\(^1\) contains several Medicaid provisions that are both controversial and unabashedly tailored to reduce enrollment in Medicaid long-term care programs. The extension of the asset transfer "look back" period and modification of the transfer penalty period methodology are expected to delay eligibility for Medicaid coverage to more than 100,000 individuals in the next five years.\(^2\) Meanwhile, the new home equity limits undermine the homestead exemption historically provided to Medicaid applicants in the financial eligibility screening process.\(^3\) Furthermore, the long battle fought between states and Medicaid applicants over annuity rules has been resolved in favor of the states by changes to the annuity rules.\(^4\)

There is one provision of the DRA that has not received the same degree of attention that other DRA provisions have, but

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which may have a notable impact on Medicaid’s coverage of long-term care (LTC). Section 6086 of the DRA, entitled “Expanded Access to Home and Community-Based Services for the Elderly and Disabled,” allows states to amend their current plan so that they can offer a package of home and community-based care services (HCBS) to individuals who would not otherwise need nursing facility care. Historically, states have only been authorized to offer HCBS to Medicaid enrollees who need nursing facility care through Medicaid “waivers.” Now, HCBS may be available to more individuals, as the increased availability may theoretically stave off some enrollees’ need for LTC and help more enrollees live independently in the community.

As attractive as the new HCBS option sounds, the outcomes that result from the option may not be as positive as it would theoretically appear. The statutory language stipulating that states may narrow their nursing facility (NF) clinical eligibility standards in order to adopt the option is critical to understanding the new option’s potential impact. Coverage for NF care is guaranteed to Medicaid enrollees who have a medical need for LTC. States may not limit the number of people to whom they will provide Medicaid NF coverage. However, some states experiencing a budget crunch resulting from high LTC costs have modified the “medical need” eligibility standard in order to reduce the number of eligible enrollees. The problem with this approach is its arbitrary nature, and states that manipulate the medical need standard for budgetary purposes will be exposed to litigation.

However, since the new option contains an express statutory allowance to change criteria, a state may adopt the new

6. 42 U.S.C.A. § 1396n(i).
7. § 1396n(c)-(e); see Julia Belian, State Implementation of the Optional Provisions of the Deficit Reduction Act, 9 ELDER’S ADVISOR 53, 77-80.
8. § 1396n(i)(1)(B).
9. § 1396a(a)(10)(A).
10. Id.
option, cap enrollment for the benefit, and narrow the state's NF clinical standard, thereby reducing the number of people to whom the state must provide LTC coverage, with significantly less risk of litigation. Thus, a state's implementation of the new option may successfully produce a deliberate reduction in Medicaid coverage instead of an expansion of coverage. Because states are already preoccupied with figuring out how to shape their Medicaid LTC programs in preparation for aging Baby Boomers, and because many states have previously sought to narrow their NF standard as means of reducing LTC costs, the new option approach may find some resonance in the offices of state Medicaid agencies.

The purpose of this article is to examine the new HCBS option and its potential to narrow NF care entitlement, to consider the new option in the context of state efforts to modify clinical eligibility standards, and to identify how far states may go in making standards more stringent. Ultimately, it is entirely up to states to decide whether they will use the new option to expand or contract coverage. Fortunately, the first state to implement the HCBS option has chosen to use it to expand coverage. Still, because of recent efforts by other states to reduce enrollment by narrowing the NF clinical standard, and because of pressure states may feel to identify ways to reduce their LTC obligations, do not lightly dismiss the possibility that a state may attempt to restrict coverage by using the HCBS option. It is therefore important to identify the limitations of the states' ability to do so.

MEDICAID COVERAGE FOR LONG-TERM CARE SERVICES

The new HCBS option is codified at 42 U.S.C.A. § 1396n(i), and it is referred to as the "[s]tate plan amendment option to provide home and community-based services for elderly and disabled

individuals." The new option grants states the authority to offer HCBS to individuals who do not need NF care and have incomes below 150% of the federal poverty level (FPL) through a Medicaid state plan amendment. This provision is contained within the statute that allows states to operate HCBS waiver programs. A review of HCBS waivers will aid in analyzing the scope of the new option.

**Nursing Facility Services and HCBS Waivers**

HCBS waivers allow states to offer alternatives to NF care. Specifically, if the state is operating an HCBS waiver, a person who qualifies for Medicaid and meets state clinical eligibility standard for NF care may receive HCBS in lieu of institutional care. NF coverage is mandatory under Medicaid, while HCBS waivers permit states to provide LTC coverage in a person's home or other community setting, instead of an institution. If a Medicaid enrollee does not have a medical need for NF care, he or she generally may not receive coverage through an HCBS waiver.

The package of waiver services may include coverage for "case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care services, and such other services requested by the state as the Secretary may approve." If a state does not operate a HCBS waiver, or if it operates one

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12. § 1396n(i).
13. § 1396n(i)(1). In 2007, the FPL is set at $10,210 in annual income for a single individual; 150% of the 2007 FPL for a single individual is $15,315. See Notice, Annual Update of the HHS Poverty Guidelines, 72 Fed. Reg. 15, 3147-3148 (Dep't of Health and Human Serv., Jan. 24, 2007).
14. § 1396n(c)-(e).
15. Id.
16. Id.
17. §§ 1396a(a)(10)(A), 1396d(a)(4)(A).
18. See § 1396n(c)(1).
19. Id.
20. § 1396n(c)(4)(B). "Other services" may include modifications to a home or assistive technology, for example.
but exercises its right to cap enrollment and consequently does not have an opening, a person who does not want to enter a NF must rely on services covered under the state’s standard Medicaid program, which might not include coverage for personal care services or case management services, and may not include coverage for adult day services or respite care services.\footnote{21}

The HCBS programs are referred to as “waivers” because a state can waive certain federal rules if it elects to operate an HCBS program.\footnote{22} If a state wants to restrict eligibility for HCBS to a discrete geographical area, it can have the mandate codified at 42 U.S.C.A. § 1396a(a)(1), which requires state-wide implementation, waived.\footnote{23} If the state wants to target its HCBS program to a select population, such as to individuals with HIV/AIDS or with traumatic brain and spinal cord injuries, the state may request waiver of the comparability mandate of section 1396a(a)(10)(B).\footnote{24} In terms of responsibilities, the statute requires states to provide assurances to the Centers for Medicare & Medicaid Services (CMS) that the states have “necessary safeguards” to protect the health and welfare of HCBS enrollees,\footnote{25} and states are required to submit annual reports on waiver impacts.\footnote{26} Most notably, the statute also requires that states’ HCBS waivers be budget neutral, which means that a state cannot spend more on HCBS waiver services than it would have spent on NF services in the absence of the waiver.\footnote{27}

\footnote{21. §§ 1396d(a)-(19), -(24).}
\footnote{22. § 1396n(c).}
\footnote{23. § 1396n(c)(3).}
\footnote{24. Id.; “[Section] 1396a(a)(10)(B) creates an equality principle by which all categorically needy individuals must receive medical assistance which is no less than that provided to other categorically or medically needy individual.” Sobky v. Smoley, 855 F. Supp. 1123, 1139 (E.D. Cal. 1994).}
\footnote{25. § 1396n(c)(2)(A).}
\footnote{26. § 1396n(c)(2)(E).}
\footnote{27. § 1396n(c)(4)(A).}
THE HCBS OPTIONAL BENEFIT

The new HCBS option allows states to expand HCBS coverage to a new population of enrollees, and states have the same freedoms that accompany other waiver programs, but without the mandates.28 First, a state does not have to submit a formal waiver proposal to adopt the new option, and instead may simply submit a state plan amendment (SPA) incorporating the proposal, much like it would do if it were adding an optional Medicaid service to an existing state coverage plan.29 Additionally, the new option does not have annual reporting requirements,30 nor is there a budget neutrality mandate.31 Furthermore, a state may have the mandate requiring state-wide implementation waived,32 and it may also impose an enrollment cap.33 The comparability provision as codified at section 1396a(a)(10)(B) is not specifically identified in section 1396n(i) as a waivable provision, but it appears from Iowa’s approved SPA that states may tailor eligibility standards to allow it to target the new option to a specific population.34

However, there are two limitations on a state’s delivery of the new option that are not similarly imposed onto states in HCBS waiver programs. First, a state’s new option may only cover services specifically identified in section 1396n(c)(4)(B), but not “other services requested by the State as the Secretary

28. See, e.g., § 1396n(i)(1).
29. Id.
30. See, e.g., § 1396n(c)(2)(E) (mandating annual reporting for other waivers and services). But see § 1396n(i) (requiring no annual reporting).
31. § 1396n(c)(4)(A).
32. § 1396n(i)(3).
33. § 1396n(i)(1)(C)(ii).
34. Iowa’s new option limits coverage to individuals who have undergone psychiatric treatment that was more intensive than outpatient care, or to individuals with histories of psychiatric illness resulting in at least one episode of continuous, professional supportive care, other than institutionalization. IOWA DEPT OF HUMAN SERVS., § 1915(i) HCBS STATE PLAN SERVICES ADMINISTRATION AND OPERATION 6 (2007), http://www.dhs.state.ia.us (search “§1915(i) HCBS State Plan Services Administration and Operation”; then follow “SMDL #06-” hyperlink) (last visited Sept. 26, 2007).
may approve."\(^{35}\) Second, there is the 150% FPL income cap.\(^{36}\) Federal law specifically allows states to provide HCBS waiver coverage to individuals with incomes up to 300% of the Supplemental Security Income Federal Benefit Rate,\(^{37}\) as well as to those with higher incomes who qualify as medically needy.\(^{38}\) However, the HCBS optional service provision appears to place a strict income cap on eligibility.\(^{39}\)

**THE CRITICAL DIFFERENCE**

There are noteworthy similarities and differences between HCBS waivers and the new option, but nothing stands out more than the differing rules on the clinical eligibility standard.\(^{40}\) The new HCBS option is designed strictly for people who do not need NF care, so the clinical eligibility standard that a state applies for NF/HCBS waiver services (LTC standard) must be separate and distinct from the clinical standard that the state chooses for the new option.\(^{41}\) The next question concerns how a state should create the new option standard.

The simplest method a state can undertake is to create a standard less stringent than the state’s current LTC standard. Given that the latter standard represents what the state already considers to be the dividing line between those who need NF care and those who does not, and given that the statute requires that the new option be provided to those who do not need NF care, this approach seems the simplest and most logical.

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35. § 1396n(i)(1).
36. Id.
37. § 1396a(a)(10)(A)(ii)(VI). For 2007, the S.S.I. FBR for a single individual is $623 a month; $1,869 in monthly income is 300% of this rate, whereas a single individual at 150% of the FPL has $1,276 in monthly income. SOC. SEC. ADMIN., FACT SHEET - 2007 SOCIAL SECURITY CHANGES (2007), http://www.ssa.gov/pressoffice/factsheets/colafacts2007.htm (last visited Sept. 26, 2007).
38. A "medically needy" person is one who meets the requirements of a categorical Medicaid population by being aged 65 years or older, and by having income that above the state’s income limit, but insufficient to cover his or her medical expenses. See § 1396a(a)(10)(C).
39. § 1396n(i)(1).
40. §§ 1396n(i)(1)-(A), -(B).
41. § 1396n(i)(1)(B).
However, the statutory language appears to envision a very different alternative for states.\textsuperscript{42} The law expressly permits a state to make its LTC standard more stringent in order to adopt the new option.\textsuperscript{43}

For example, suppose a state that wishes to adopt the new option currently requires people seeking LTC coverage eligibility to demonstrate a need for assistance with three activities of daily living (ADL).\textsuperscript{44} In order to adopt the new option, the state could simply apply a two ADL eligibility standard in order to satisfy the requirement that the new option standard differ from the state's LTC standard.\textsuperscript{45} Again, this seems to be the most logical approach.

Specifically, if the state already considers a person with three ADLs to need NF care, a person receiving benefits designed for individuals who do not need NF care should have to meet a less stringent standard than the three ADL standard.\textsuperscript{46} However, the law allows a state to narrow the NF/HCBS waiver standard to four ADLs, and adopt three ADLs as the standard

\textsuperscript{42.} Id.

\textsuperscript{43.} Id.

\textsuperscript{44.} Activities of daily living include, among others, eating, bathing, dressing, walking, toilet use, and grooming. Many consider the LTC standards that are based strictly on an ADL test as too narrow, in that they do not adequately gauge an individual’s functional capacity. For example, a person with a cognitive impairment may be able to perform a full range of ADLs, but he or she may need significant prompting to do the tasks, as well as supervision during the task. See, e.g., JANET O'KEEFE, AARP PUB. POLICY INST., PEOPLE WITH DEMENTIA: CAN THEY MEET MEDICAID LEVEL-OF-CARE CRITERIA FOR ADMISSION TO NURSING HOMES AND HOME AND COMMUNITY-BASED WAIVER PROGRAMS? 1-4 (1999), available at http://assets.aarp.org/rgcenter/health/9912_dementia.pdf. The use of the ADL test as an illustration is not meant to imply that strict ADL tests are more popular or even preferable, but rather, to demonstrate the impact that the new option may have on state LTC standards in the most straightforward fashion. However, it should be noted that the statutory language specifically grants states the authority to apply a strict ADL test for the new option. See 42 U.S.C.A. § 1396n(i)(1)(D)(i).

\textsuperscript{45.} § 1396n(i)(1)(B).

\textsuperscript{46.} The statute allows for the continuation of federal financial participation (FFP) for NF or HCBS waiver services provided to people who qualified under the former less stringent standard, “without regard to whether such individuals satisfy the more stringent eligibility criteria established under [the statute] until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.” 42 U.S.C.A. § 1396n(i)(H)(5).
for the new option.\textsuperscript{47} If a state adopted this approach, Medicaid entitlement to NF care would narrow. Individuals applying for LTC coverage with assistance needs in exactly three ADLs, who were formerly guaranteed coverage for some form of LTC services, would now only be covered if the state had room on a finite list.\textsuperscript{48} Even if there was room, the income cap on the benefit could bar coverage; such a bar that would not be imposed if the person was eligible for LTC.\textsuperscript{49}

**WHICH WAY WILL STATES GO AND HOW FAR CAN THEY GO?**

Under the federal law, states have the authority to tighten their clinical LTC standard in order to adopt the new option.\textsuperscript{50} The question remains whether states will take this direction. Iowa, which was the very first state to receive approval, did not.\textsuperscript{51} Instead, Iowa chose to expand coverage through the new option.\textsuperscript{52}

However, while it is good news that one state has expanded coverage through the new option, this news is tempered by some harsh realities. First, LTC is extremely expensive; Medicaid paid $193 billion for LTC in 2004,\textsuperscript{53} and this amount is expected to double in the next ten years.\textsuperscript{54} Second, it is no secret that when costs increase, states consider tightening their clinical eligibility standard for LTC coverage.\textsuperscript{55} Within the last five

\begin{itemize}
\item \textsuperscript{47} Id.
\item \textsuperscript{48} § 1396n(i)(1)(C)(ii).
\item \textsuperscript{49} § 1396n(i)(1) (limiting eligibility to those with incomes not greater than 150\% of the federal poverty level).
\item \textsuperscript{50} § 1396n(i)(1)(B).
\item \textsuperscript{51} See HCBS HABILITATION SERVICES PROGRAM, supra note 11.
\item \textsuperscript{52} Id.
\item \textsuperscript{53} U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICAID LONG-TERM CARE FEW TRANSFERRED ASSETS BEFORE APPLYING FOR NURSING HOME COVERAGE; IMPACT OF DEFICIT REDUCTION ACT ON ELIGIBILITY IS UNCERTAIN 1, (Mar. 2007), available at http://www.gao.gov/new.items/d07280.pdf.
\item \textsuperscript{54} Id. (citing CONG. BUDGET OFFICE, STATEMENT BEFORE THE U.S. SENATE SPECIAL COMM. ON AGING, MEDICAID SPENDING GROWTH AND OPTIONS FOR CONTROLLING COSTS (July 2006).
\item \textsuperscript{55} JANET O'KEEFE ET AL., ALZHEIMER'S ASS'N, MEDICAID ELIGIBILITY CRITERIA FOR LONG TERM CARE SERVICES: ACCESS FOR PEOPLE WITH ALZHEIMER'S DISEASE AND OTHER DEMENTIAS 1 (2006), available at http://www.alz.org/national/doc
\end{itemize}
years, at least three states – Kentucky, Oregon, and West Virginia – have changed their LTC standards to reduce costs, well before they have actually experienced the increased demand that the growth of the aging population is expected to create.\(^5\) Iowa’s decision to leave its LTC standard alone and to expand coverage through adoption of the new option does not necessarily eliminate the fear that other states may use the new option to reduce coverage by tightening standards.

**OTHER OPTIONS**

Interestingly, a third approach exists between the contrasting approaches of expanding coverage and tightening LTC standards. Specifically, Vermont’s Choices for Care (CFC) Medicaid waiver,\(^5\) which was implemented in October 2005,\(^5\) guarantees coverage for non-institutional LTC services to all individuals who meet the state’s LTC clinical eligibility standard.\(^5\) CFC also monitors the program’s growth by using a spending cap for those on the lower end of the clinical spectrum.\(^6\)

The starting point in CFC was the split of Vermont’s single LTC clinical eligibility standard into three standards: highest need, high need, and moderate need.\(^6\) Individuals who meet the highest need standard are entitled to choose either NF
coverage or community-based coverage. Enrollees who meet the high need standard are also entitled to make the same choices, but they only get coverage for services if funding is available. Moderate need individuals are entitled to a small package of community-based services, including case management, as well as homemaker or adult day services, and they too only receive coverage for the services if funding is available.

The highest need standard is more stringent than the standard Vermont had applied prior to implementation of CFC, meaning that the state narrowed the entitlement to LTC when it adopted the program. The high need standard is most comparable to the old standard, and Vermont’s high need population is akin to the population eligible for the new option in a state that narrows its LTC standard. Previously, members of this population would have been entitled to at least NF care coverage; now, they may only get coverage for services if there is funding available and room within an enrollment cap.

However, CFC does not apply different financial eligibility rules to highest need and high need individuals, and it allows people with incomes up to 300% of the Supplemental Security Income Federal Benefit Rate and people who are medically needy to qualify. Additionally, spouses of high need individuals are entitled to the spousal impoverishment

63. CHOICES FOR CARE, supra note 59, at 3.
64. Id. at 26.
65. VERMONT LONG-TERM CARE PLAN, supra note 62, at 11.
67. VERMONT LONG-TERM CARE PLAN, supra note 62, at 23.
protections of section 1396r-5. Moreover, Vermont has placed a spending cap on the high need population, not an enrollment cap. Vermont is counting on the increased availability of non-institutional services to reduce overall Medicaid LTC spending, which Vermont hopes will enable its program to serve all who meet the high need standard. Thus, while CFC narrowed the LTC entitlement, it did not constrict other eligibility requirements; it is designed to provide coverage to all enrollees who need LTC, and even to those who do not (i.e., those meeting the moderate need standard).

Vermont's program has received a significant amount of attention. Indeed, the front page of the Wall Street Journal declared that CFC is "an effort being watched around the nation." But there is a problem: the starting point in Vermont's effort to control LTC spending was a change in the Medicaid LTC clinical eligibility standard. A state that wants to incorporate this as part of rebalancing Medicaid LTC may still view the new option as the more expedient alternative. First, CFC is still very new, so it may be too soon for state policymakers to declare it a success. Second, it took Vermont almost two years to receive approval for the CFC waiver, a process from which states may shy away. Lastly, CMS imposes requirements that accompany the waiver, including a budget.

68. See generally § 1396r-5.
69. VERMONT LONG-TERM CARE PLAN, supra note 62, at 4.
70. Id. at 2-4.
71. Id.
74. In October of 2003, Vermont submitted to CMS the final version of CFC, which received approval in June of 2005. See CHOICES FOR CARE, supra note 59, at 25; KEY PROGRAM CHANGES AND QUESTIONS, supra note 58, at 1.
neutrality mandate and reporting requirements, both of which would not apply to the new option.\textsuperscript{75}

Thus, despite the directions chosen by Iowa and Vermont, the incentive for states to tighten their clinical LTC standards may still be too strong for them to resist. With this possibility looming, it is important to at least identify the existing limits on states' authority to narrow the standards.

**SKILLED NURSING FACILITY CARE**

At minimum, a tightened clinical LTC standard cannot become a skilled standard. Skilled NF care is the highest level of care provided in a NF, and it includes services provided on a daily basis, such as intravenous feeding, insertion and replacement of catheters, and care of a colostomy.\textsuperscript{76} Services such as overall management of a care plan, as well as observation and assessment of an individual's condition, may also qualify as skilled services, so long as the skills of a technical or professional person are required.\textsuperscript{77} Skilled care is commonly provided in a separate NF, and the Medicare program is the primary insurer of skilled care.\textsuperscript{78}

Historically, Medicaid mandated coverage for skilled care while treating "intermediate" NF care as a discretionary Medicaid service to be elected by the states at will. This changed in 1987 when Congress deleted the word "skilled" from the statutory provision identifying the mandatory Medicaid service,


\textsuperscript{77} 42 C.F.R. § 409.33(a) (2006).

thus entitling beneficiaries to "nursing facility services." 79 Under the broader nursing facilities services definition, an enrollee may be eligible for Medicaid coverage if he or she has a mental or physical condition requiring services "above the level of room and board," which "can be made available only through institutional facilities." 80 This is commonly referred to as a "custodial" level of care. 81

Although a state narrows the allowances granted by the federal law when it limits its definition of NF care to skilled care, it might still try to apply a skilled standard as the clinical standard for Medicaid LTC eligibility. 82 A lawsuit currently pending in Maryland alleges that the state Medicaid agency applies a skilled LTC clinical standard when determining Medicaid eligibility. 83 Maryland's standard requires a person to need services that can be provided only "under the supervision of licensed health care professionals." 84 The plaintiffs allege that the clause renders the Medicaid LTC eligibility standard a skilled standard because the requirement only appears in the definition of skilled nursing facility care within the Code of Federal Regulations. 85

Vermont also encountered problems with CMS on this issue when it shaped the CFC's highest need standard. 86 After initially reviewing Vermont's proposal, CMS said,

Your proposal appears to restrict the nursing facility benefit to individuals who require the skilled nursing care and related services described in subparagraph (A)

81. See 42 C.F.R. § 411.15(g) (2006); See also Harvey L. McCormick, 1 Medicare and Medicaid Claims and Procedures § 2:28 (4th ed. 2007).
83. Id.
86. Vermont Long-Term Care Plan Responses, supra note 73, at 9-15.
The nursing facility benefit may not be restricted in this manner. The intent of Congress in OBRA '87 was clearly to combine the Intermediate Care Facility and Skilled Nursing Facility level of care into a single benefit.87

In the CFC's final form, the highest need standard does not appear to require an individual to need skilled care.88

Even as some states may flirt with the idea of imposing a skilled standard, does any LTC standard that is less than skilled become unassailable? Can a state amend its LTC standard to something slightly below "skilled" in order to adopt the new option? Historically, the answer has appeared to be no. Keeping a standard below skilled has not necessarily been enough, as other Medicaid statutory provisions curtail state discretion.89

MEDICAL NECESSITY AND REASONABLE ELIGIBILITY STANDARDS

Medicaid's reasonable standards provision is the primary provision at issue in this context. In providing mandatory coverage of NF services, federal law requires states to develop "reasonable standards" for determining eligibility.90 This has been interpreted to require that state Medicaid plans provide "medically necessary" treatment in order for the plans to "comport with the objectives of the Act."91 "The concept of medical necessity is the set measure—the touchstone—for evaluating the reasonableness of a participating state's Medicaid standards."92

87. Id. at 11.
89. See Weaver v. Reagen, 886 F.2d 194, 197-98 (8th Cir. 1989).
90. 42 U.S.C.A. § 1396a(a)(17).
91. Weaver, 886 F.2d at 198 (emphasis added).
In evaluating whether a treatment for an applicant is a medical necessity, a state must at least consider the opinion of the applicant's treating physician. However, the state does not have to defer entirely to the treating physician's opinion. Indeed, states are "free to define medical necessity as broadly or as narrowly as required to fulfill the state's policy goals." With regard to a state's LTC clinical eligibility standard, at least one court has held that a state is not required to consider all aspects of a person's condition when determining whether he or she "needs" care.

Ultimately, the Medicaid Act and its regulations both protect and limit the states' discretion. Generally, states have discretion to develop their own clinical LTC standard, and very few standards are similar to one another. But where the principles of the medical necessity "touchstone" and the states' discretion to define it collide is when a state attempts to change its clinical eligibility standard, and a perfect example of this collision recently occurred in Kentucky.

**Kerr v. Holsinger: Limits on Medical Necessity**

In 2003, Kentucky tightened its Medicaid LTC clinical eligibility standard in order to reduce $45 million from the state's Medicaid budget. The state had previously required applicants and beneficiaries to demonstrate a need for assistance

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95. Holman, 757 N.E.2d at 387.
97. Smith v. Rasmussen, 249 F.3d 755, 759 (8th Cir. 2001).
98. See, e.g., O'KEEFE ET AL., supra note 55, at 3.
100. Id.
with two ADLs among a list of twelve, but then the state reduced the list to nine and increased the ADL showing to three.\textsuperscript{101} As a result, more than 3,000 Medicaid beneficiaries that had previously received coverage for NF or HCBS care lost eligibility.\textsuperscript{102}

A suit was brought on behalf of Medicaid applicants and beneficiaries to challenge the changes made to Kentucky’s Medicaid LTC clinical eligibility standard.\textsuperscript{103} The plaintiffs alleged that the state altered the clinical eligibility standard solely to reduce state Medicaid LTC spending, and no evidence indicated that the change was prompted by a medical review’s finding that the prior standard was an inaccurate gauge of a person’s need for LTC.\textsuperscript{104} As such, the plaintiffs asserted that application of the new standard should be enjoined because it was illegal for the state to change the clinical eligibility standard of a mandatory Medicaid service for the sole purpose of reducing state Medicaid spending.\textsuperscript{105}

The Kerr court agreed.\textsuperscript{106} The court recognized that states, in fact, have discretion to establish standards of need, and they may make budget-motivated decisions when shaping the scope of Medicaid programs.\textsuperscript{107} However, the court held that changing a medical need standard to suit the state budget was not within the bounds of state discretion.\textsuperscript{108} The court stated:

Medicaid regulations adopted for the wrong reasons, i.e., without a Medicaid-related or a health-related purpose, are contrary to the purposes of the Act because they are inherently arbitrary, unreasonable and invalid. Thus, reducing mandatory benefits to qualified recipients by manipulating eligibility standards in order to make up for budget deficits is

\textsuperscript{101} Id. See 907 KY. ADMIN. REGS. 1:022 (2007).
\textsuperscript{102} Medicaid; Kentucky’s Governor Asks for Patience from Advocates of Rescinding Program Cuts, HEALTH & MED. WK., Jan 12, 2004, at 641.
\textsuperscript{103} Kerr, 2004 WL 882203.
\textsuperscript{104} Id.
\textsuperscript{105} Id.
\textsuperscript{106} Id.
\textsuperscript{107} Id.
\textsuperscript{108} Id.
unreasonable and inconsistent with Medicaid objectives because it exposes recipients to whimsical and arbitrary decisions which the Act seeks to avoid. Focusing solely on budgetary concerns simply does not rise to the level of a reasonable standard for determining eligibility for long-term care services and is inconsistent with Medicaid objectives.\textsuperscript{109}

Thus, it seems that \textit{Kerr} stands for the proposition that a state's motivation is fair game for scrutiny when a state changes its Medicaid LTC clinical eligibility standard. A state standard may be safe from challenge if it is not "skilled," but where the standard is altered, a state must be prepared to show that the alteration did not relate solely to the state's financial position.\textsuperscript{110}

A state may still face problems regarding standard changes, even with a non-financial motive for altering its Medicaid LTC standard.\textsuperscript{111} Such an alteration has the potential to become a public relations nightmare for a state.\textsuperscript{112} In Kentucky, the changes prompted a grassroots coalition of Medicaid advocates to participate in community protests, which induced the governor to direct communication.\textsuperscript{113} In 2006, West Virginia similarly attempted to modify its clinical LTC standard to reduce the HCBS Waiver population, and the public and legislative outcry was intense.\textsuperscript{114} The governor ultimately ordered the state agency to settle a lawsuit brought on behalf of HCBS enrollees on the eve of a preliminary injunction hearing.\textsuperscript{115}

The issue of whether strict budgetary considerations motivated plan changes was the common element involving the changes put forth by Kentucky and West Virginia. For purposes

\textsuperscript{109} Id.
\textsuperscript{110} See generally id.
\textsuperscript{111} See generally id.
\textsuperscript{112} Id.
\textsuperscript{113} Karla Ward, Crowd Protests Cuts in Medicaid: Fletcher Says Goal is to Restore Care, Asks for Patience, LEXINGTON HERALD LEADER, Dec. 17, 2003, at B6.
\textsuperscript{115} See Long, supra note 56, at A1.
of a potential legal battle, it seems imperative that the state be able to justify a changed standard on other grounds.116

Of course, one justification for a change in standards that seems rarely asserted, at least in the context of clinical LTC standards, is that a modification directly resulted from input by medical professionals who concluded that the prior standard insufficiently evaluated medical need.117 For example, in 1980, the Eighth Circuit held that Iowa’s refusal to provide coverage for sex reassignment surgeries violated the Medicaid Act’s medically necessary standard118 because the state “had not consulted medical professionals, and had disregarded the current accumulated knowledge of the medical community.”119 In 2001, the Eighth Circuit again visited the issue of Iowa’s refusal to cover sex reassignment surgeries, and this time ruled in the state’s favor; the state, post-Pinneke, had contracted with a federally designated medical peer review organization, which recommended that Iowa not cover the surgeries because of “the lack of consensus in the medical community [about the surgery’s appropriateness] and the availability of other treatment options.”120

However, recent examples of state changes to clinical LTC standards are seemingly not products of similar medical community evaluations, and the absence of such evaluations should make alterations inherently suspect. The statutory language of the new option expressly allows a state to change the standard, which would seem to support a state seeking to justify a change. But given the principles from the cases described above, the question exists whether the limits of states’ discretion can be ascertained.

116. See id. See also Ward, supra note 113.
117. See Pinneke v. Preisser, 623 F.2d 546 (8th Cir. 1980). See also Smith v. Rasmussen, 249 F.3d at 755.
118. Pinneke, 623 F.2d at 549-50.
119. Rasmussen, 249 F.3d at 760 (citing Pinneke, 623 F.2d at 549-50).
120. Rasmussen, 249 F.3d at 760.
CONSIDERING THE NEW OPTION

Courts have struggled with Medicaid-related issues in litigation, and their struggle will likely increase if courts are forced to balance the express statutory authority allowing states to tighten a clinical LTC standard against the limits on that authority imposed by section 1396(a)(17). For now, the opposing goals seem rather clear, but there is a potential for battle over the area in between.

A state that tightens its clinical LTC standard to adopt the new benefit may not render its LTC standard a skilled standard. To interpret section 1396n(i) as a provision allowing for a state to tighten its clinical standards in order to make its new standard “skilled” is to interpret the section as impliedly repealing OBRA '87’s Medicaid amendments. A court will not do this in the absence of “a clearly established congressional intention,” and no such intent to allow for skilled standards through section 1396n(i) exists.

By the same token, it seems easy to identify the safest course for a state to take. Consider again the ADL test discussed. Where a state applies a three-ADL test as its clinical LTC

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121. The Mertz court recognized the difficulty in interpreting the Medicare Act itself. “The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize. The Act has been called ‘an aggravated assault on the English language, resistant to attempts to understand it.’” Mertz, 155 F.Supp.2d at 420 n.6 (quoting Schweiker v. Gray Panthers, 453 U.S. 34, 43, (1981)). “The Medicaid Act has been characterized as one of the ‘most completely impenetrable texts in human existence,’ and ‘dense reading of the most tortuous kind.’” Mertz, 155 F.Supp.2d at 420 n.6 (quoting Rehabilitation Ass'n of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994)). “The court has nothing but sympathy for officials who must interpret or administer the Act.” Mertz, 155 F.Supp.2d at 420 n.6.

122. See id.

123. See id.


126. See § 1396n(i)(5). See generally Kerr, 2004 WL 882203.
standard, a change that results in applying the same three ADL test to the new option, and a four-ADL test as the new LTC standard, will be very hard to challenge so long as the four-ADL test is not a skilled standard. This course resembles Vermont's approach, where the high need standard is comparable to the state's former LTC standard, and individuals with greater needs fall into the highest need category and are guaranteed coverage. The bottom line is that section 1396n(i) specifically allows states to make changes. In this example, the change is essentially gradual, and there exists at least some connection between the former standard and the new standard. Because a court will have to give meaning to the statutory allowance for a change, it will likely look at this example as one envisioned by Congress when it enacted the statute.

Between these ends is where disputes will focus. Suppose a state raises its clinical LTC standard from three to five ADLs, and then also applies the three-ADL test as the standard for the new option. In this scenario, the state will have formerly guaranteed coverage to people needing assistance in three and four ADLs or more. However, in adopting the new benefit, the state will have preserved coverage, albeit more limited, for people with needs in three ADLs, and it will have eliminated coverage entirely for those with four. This approach could easily expose the state to claims of arbitrariness.

Conversely, if the gap between old and new coverage plans creates problems for a state, what if the state decides to make the new option standard four ADLs, and the LTC standard five? In this scenario, can a state allege that the basis for the change was

127. See generally § 1396n(i)(5).
128. VERMONT LONG-TERM CARE PLAN RESPONSES, supra note 73, at 1-15.
129. See §§ 1396a(a), 1396n(i). See also Kerr, 2004 WL 882203.
130. The specific allowance in the statute for grandfathering current enrollees may further help a state's cause, from both a legal and public relations standpoint. The Kentucky and West Virginia agencies were hurt by the fact that they terminated individuals who had experienced no improvement in their medical conditions since they qualified for Medicaid coverage. See § 1396n(i); Long, supra note 116, at A1.
131. See, e.g., O'KEEFE ET AL., supra note 56.
the adoption of the new option? Individuals who formerly were
guaranteed coverage for some form of LTC (individuals with
needs in strictly three ADLs) would be considered medically
ineligible for LTC altogether. If these individuals cannot even
receive coverage under the new option, they may raise
allegations that adopting the new option was not the sole basis
for the coverage change.\textsuperscript{132}

A state would not want to find itself having to answer
questions concerning what other basis justified the coverage
change. Again, the statute specifically allows for a tightening of
the LTC standard for the purpose of adopting the new option.\textsuperscript{133}
But just as the statute cannot be read to have repealed the
Medicaid Act's prohibition on a skilled LTC standard, it cannot
be read to have repealed the reasonable standards mandate,
which among other things, limits the state's ability to change a
standard of medical need.\textsuperscript{134} The further a state moves away
from its former standard in adopting the new option, the more
the reasonable standards provision will be implicated.\textsuperscript{135}

\section*{Conclusion}

Pinpointing where the statutory grant allowing states to change
a clinical LTC standard ends and where a violation of the
reasonable standards mandate begins will likely challenge
courts.\textsuperscript{136} Courts are apt to confront this dilemma where a state
changes its policies in a way that appears to interfere with an
individual's ability to obtain Medicaid LTC coverage.\textsuperscript{137} States
will soon face the extraordinary task of providing LTC coverage

\textsuperscript{132} See Kerr, 2004 WL 882203.
\textsuperscript{133} See § 1396n(i).
\textsuperscript{134} See Pub. L. No. 100-203, § 4211(h)(6)(A), 101 Stat. 1330-206 (codified as
See also 42 U.S.C. § 1396n(i).
\textsuperscript{135} See § 1396n(i). See generally §§ 1396a(a)(17).
\textsuperscript{136} See Edward Alan Miller, \textit{State Discretion and Medicaid Program Variation in
Long-Term Care: When Is Enough, Enough?}, 14 J. AGING & SOC. POL'Y 15, 16 (2002)
(discussing the court's interaction of state and federal Medicaid regulations).
\textsuperscript{137} See \textit{id}. 
for the booming aging population, and states may wish for even greater discretion is establishing state coverage plans.\textsuperscript{138} However, as the recent stories from Kentucky and West Virginia demonstrate, manipulating a standard of medical need to reduce outlays is fraught with problems.\textsuperscript{139} Even though states have received some encouragement by Congress to pursue this path, it is not a good approach to take.

Ideally, states should monitor the progress of Vermont and Iowa closely before deciding to use their discretion to constrict coverage by way of the new option. Certainly in the case of Vermont, and to a lesser extent Iowa, the aim is to emphasize community-based choices as a method of monitoring LTC costs. States have been more willing to seek Money Follows the Person grants,\textsuperscript{140} a program designed to deemphasize the Medicaid program's reliance on and bias toward institutional care as the delivery method for LTC. Policymakers, consumers, and advocates seem to strongly support the movement toward community-based care. There is still time to study the impact that significantly increased reliance on the delivery method will have on state programs before resorting to the sort of rationing that the new options statute allows.

\begin{itemize}
\item \textsuperscript{138} See id. at 29.
\item \textsuperscript{139} Long, supra note 56, at A1.
\item \textsuperscript{140} The Money Follows the Person program provides federal grants to states that allow them move people who are receiving Medicaid coverage in nursing facilities back to the community in order to "[i]ncrease the use of home and community-based, rather than institutional, long-term care services." 120 Stat. 4 (codified as amended at 42 U.S.C.A. § 1396a). Seventeen states were awarded grants in the first round of awards. CTR. FOR MEDICARE AND MEDICAID SERV., MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION: FIRST TIER AWARD SUMMARY, http://www.cms.hhs.gov/DeficitReductionAct/Downloads/States1st%20Tierweb(2).pdf (last visited Sept. 26, 2007); see also Belian, supra note 7, at 83-4.
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