

Medicaid and HCBS Basics: 1915(c), 1915(i), and HCBS in Managed Care

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Center for Medicaid and CHIP Services
Disabled and Elderly Health Programs Group

Purpose of Session

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- Provide an overview of different approaches available through the Medicaid program that States may use to provide home and community-based services and supports

Medicaid Authorities that include HCBS

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- **Medicaid State Plan Services – Section 1905(a) of the Social Security Act (the Act)**
- **Medicaid Home and Community Based Services Waivers (HCBS)– Section 1915(c)**
- **Medicaid HCBS State Plan Option – 1915(i)**
- **Medicaid Self-directed Personal Assistance Services State Plan Option - 1915(j)**
- **Medicaid Community First Choice Option– 1915(k)**

Medicaid Authorities for HCBS (cont'd.)

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- **Medicaid Managed Care Authorities**
 - Section 1915(a)
 - Section 1915 (b)
 - Section 1115
- **Section 1115 demonstration programs**

Medicaid in Brief

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- States determine their own unique programs
- Each State develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, States elect to provide other services (“optional services”)
- States choose eligibility groups, services, payment levels, providers

Medicaid State Plan Requirements

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- States must follow the rules in the Act, the Code of Federal Regulations (generally 42 CFR), the State Medicaid Manual, and policies issued by CMS
- States must specify the services to be covered and the “amount, duration, and scope” of each covered service
- States may not place limits on services or deny/reduce coverage due to a particular illness or condition.

Medicaid State Plan Requirements (cont'd.)

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- Services must be *medically necessary*
- Third party liability rules require Medicaid to be the “payor of last resort”
- Generally, services must be available Statewide
- Beneficiaries have freedom of choice of providers

Medicaid State Plan Requirements (cont'd.)

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- State establishes provider qualifications
- State enrolls all willing and qualified providers
- Establishes payment for services (4.19-B pages)
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

Medicaid State Plan Services

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MANDATORY

- Physician services
- Laboratory & x-ray
- Inpatient hospital
- Outpatient hospital
- EPSDT
- Family planning
- Rural and federally-qualified health centers
- Nurse-midwife services
- NF services for adults
- Home health

OPTIONAL

- Dental services
- Therapies – PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- ICF/IID
- PRTF for <21
- Rehabilitative services
- 1915(i) State plan HCBS
- Inpatient hospital services [other than those provided in an Institution for Mental Diseases (IMD)]
- Services for individuals 65+ in IMDs
- 1915(k) Community First Choice Option

HCBS under the State Plan

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Some HCBS are Available through the regular State plan:

- Personal Care
- Home Health (nursing, medical supplies & equipment, appliances for home use, optional PT/OT/Speech/Audiology)
- Rehabilitative Services
- Targeted Case Management
- Self-directed Personal Care

Medicaid Waivers

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- Title XIX permits the Secretary of Health & Human Services - through CMS - to waive certain provisions required through the regular State plan process:

For 1915(c) HCBS waivers, the provisions that can be waived are related to:

- Comparability (amount, duration, & scope)
- Statewideness
- Income and resource requirements

1915(c) HCBS Waivers

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- 1915(c) HCBS waiver services complement and/or supplement the services that are available through:
 - ❖ the Medicaid State plan
 - ❖ other Federal, state and local public programs
 - ❖ supports from families and communities

Medicaid HCBS Waivers -1915(c)

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- Is the major tool for meeting rising demand for long-term services and supports
- Permits States to provide HCBS to people who would otherwise require Nursing Facility (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) or hospital Level of Care
- Serves diverse target groups
- Services can be provided on a less than statewide basis
- Allows for participant-direction of services

Basic 1915(c) Waiver Facts

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- There are more than 315 Waivers in operation across the country.
- 1915(c) waivers are the primary vehicle used by States to offer non-institutional services to individuals with significant disabilities.
- Package of HCBS is designed as an alternative to institutional care, supports community living & integration and can be a powerful tool in a State's effort to increase community services.

Final Rule CMS 2249-F

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- CMS published Final Regulations on January 16, 2014, that became effective on March 17, 2014, to implement changes in the current regulations for 1915(c) waivers.
- Changes in the current regulations for 1915(c) waivers, including option to combine multiple target groups in one waiver, home and community-based settings, person-centered planning, public notice, and additional compliance options for CMS.
- More information about the final regulation is available at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Section 1915(c) HCBS Waivers: Permissible Services

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- Home Health Aide
- Personal Care
- Case management
- Adult Day Health
- Habilitation
- Homemaker
- Respite Care

For chronic mental illness:

- **Day Treatment/Partial Hospitalization**
- **Psychosocial Rehabilitation**
- **Clinic Services**
- **Other Services**

1915(c) HCBS Waiver Requirements

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- **Costs:** HCBS must be “cost neutral” as compared to institutional services, on average for the individuals enrolled in the waiver.
- **Eligibility & Level of Care:** Individuals must be Medicaid eligible, meet an institutional level of care, and be in the target population(s) chosen & defined by the state.
- **Assessment & Plan of Care:** Services must be provided in accordance with an individualized assessment and person-centered service plan.
- **Choice:** Not waived under 1915(c) - HCBS participants must have choice of all willing and qualified providers.

1915(c) HCBS Waiver Processing

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- **Processing:**
 - CMS approves a new waiver for a period of 3 years. States can request a period of 5 years if the waiver will include persons who are dually eligible for Medicaid & Medicare.
 - States may request amendments at any time.
 - States may request that waivers be renewed; CMS considers whether the State has met statutory/regulatory assurances in determining whether to renew.
 - Renewals are granted for a period of 5 years.

HCBS Waiver Quality

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- States must demonstrate compliance with waiver statutory assurances
- States must have an approved Quality Improvement Strategy: an evidence-based, continuous quality improvement process

Quality in HCBS Waivers

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1915(c) Federal Assurances

- Level of Care
- Service Plans
- Qualified Providers
- Health and Welfare
- Administrative Authority
- Financial Accountability

HCBS Waiver Application and Instructions

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- Waiver applications are web-based: *Version 3.5 HCBS Waiver Application*
- The application has a robust set of accompanying instructions: *Instructions, Technical Guide, and Review Criteria*
- Available at
<https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp>

1915(i) State Plan HCBS — Key Features

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- Section 1915(i) established by DRA of 2005; became effective January 1, 2007
- State option to amend the state plan to offer HCBS as a state plan benefit
- Unique type of State plan benefit with similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care now required under 1915(c) HCBS waivers

1915(i) State plan HCBS

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- Modified under the Affordable Care, effective October 1, 2010:
 - Added state option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a waiver
 - Added state option to disregard comparability (target populations) for a 5 year period with option to renew with CMS approval, and states can have more than one 1915(i) benefit
 - Expanded the scope of HCBS states can offer
 - Removed option for states to limit the number of participants and disregard state-wideness

1915(i) Services

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Any of the statutory 1915(c) services:

- Case management
- Homemaker
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation
- Respite Care
- For Chronic Mental Illness:
 - Day treatment or Partial Hospitalization
 - Psychosocial Rehab
 - Clinic Services
- Other Services necessary to live in the community

Who May Receive State plan HCBS?

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- Individuals eligible for medical assistance under the State plan; and
- Meet state-defined **needs-based criteria**; and
- Reside in the community; and
- Have income that does not exceed 150% of FPL .

- States also have the option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a HCBS waiver.

1915(i) Needs-Based Criteria

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- Determined by an individualized evaluation of need (e.g., individuals with the same condition may differ in ADLs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are not:
 - descriptive characteristics of the person, or diagnosis
 - population characteristics
 - institutional levels of care

1915(i) Needs-Based Criteria

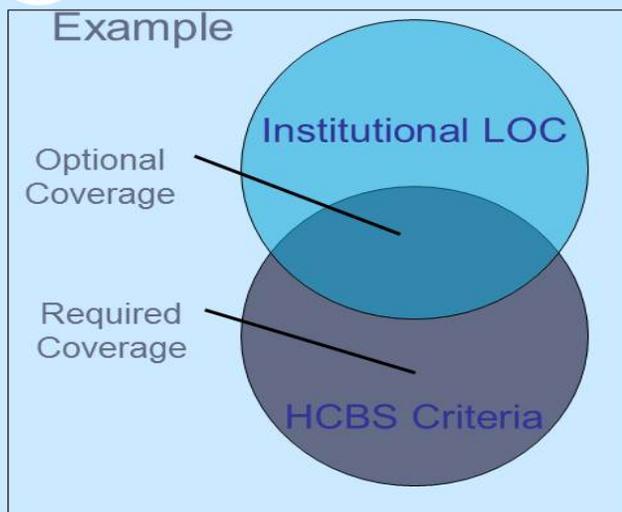
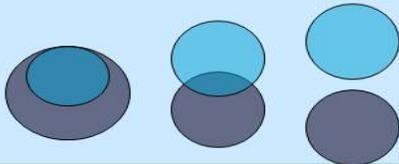
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- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
 - Must include some individuals with less need than institutional LOC
 - and May include individuals at institutional LOC, (but not in an institution)

1915(i) Needs-Based Criteria

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- Eligibility criteria for HCBS benefit may be narrow or broad
- HCBS eligibility criteria may overlap all, part, or none, of the institutional LOC:



1915(i) State plan HCBS: Requirements

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- Independent Evaluation to determine program eligibility
- Individual Assessment of need for services
- Individualized Person-Centered Service Plan
- Projection of number of individuals who will receive State plan HCBS
- Payment methodology for each service
- Quality Improvement Strategy: States must ensure that HCBS meets Federal and State guidelines
- Home and Community-Based Setting Requirements

Self-Direction in 1915(i)

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- **State Option to include services that are planned and purchased under the direction and control of the individual (or representative)**
- **May apply to some or all 1915(i) services**
- **May offer budget and/or employer authority**
- **Specific requirements for the service plan: must include the self-directed HCBS, employment and/or budget authority methods, risk management techniques, financial management supports, process for facilitating voluntary and involuntary transition from self-direction**

Final Rule CMS 2249-F

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- Effective date: March 17, 2014
- More information about the final regulation is available at:

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Medicaid HCBS Provided in a Managed Care Delivery System

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- HCBS are usually provided as “fee for service” – service is delivered, a claim is filed, and payment made
- HCBS can also be provided as part of a managed care delivery system, which generally offers a capitated payment arrangement, using one of several Medicaid authorities:
 - 1915(a) – contracting option
 - 1915(b) – waiver
 - 1115 – demonstration authority

Medicaid Managed Care Authorities

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- Section 1915(a) – voluntary contract with a managed care organization that agrees to provide certain State plan services, including HCBS in a capitated arrangement
- Section 1915(b) waiver – managed care delivery system for State plan services that may restrict providers, use selective contracting, use locality as central broker, use “savings” to provide additional services generated through savings

Section 1115 Demonstration Projects

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- Section 1115 authority may be used when a State seeks to demonstrate whether a new service or intervention would lead to a change in Medicaid policy.
- The Secretary may waive compliance with any of the requirements of section 1902 of the Social Security Act.
- Services may be reimbursed as fee-for-service or under a managed care arrangement.