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

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

Purpose of Session

- 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

- 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.)

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

Medicaid in Brief

- 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

- 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.)

- 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.)

- 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

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

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

- 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

- 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)

- 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

- 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

- 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

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

<u>For chronic mental illness</u>:

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

- **Other Services**

1915(c) HCBS Waiver Requirements

- **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

- **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

- 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

1915(c) Federal Assurances

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

HCBS Waiver Application and Instructions

- 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

- 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

- 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

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?

- 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

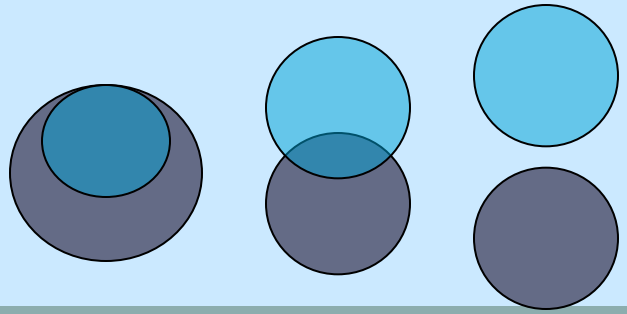
- Determined by an individualized evaluation of need (e.g., individuals with the same condition may differ in ADLs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are <u>not</u>:
  - descriptive characteristics of the person, or diagnosis
  -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

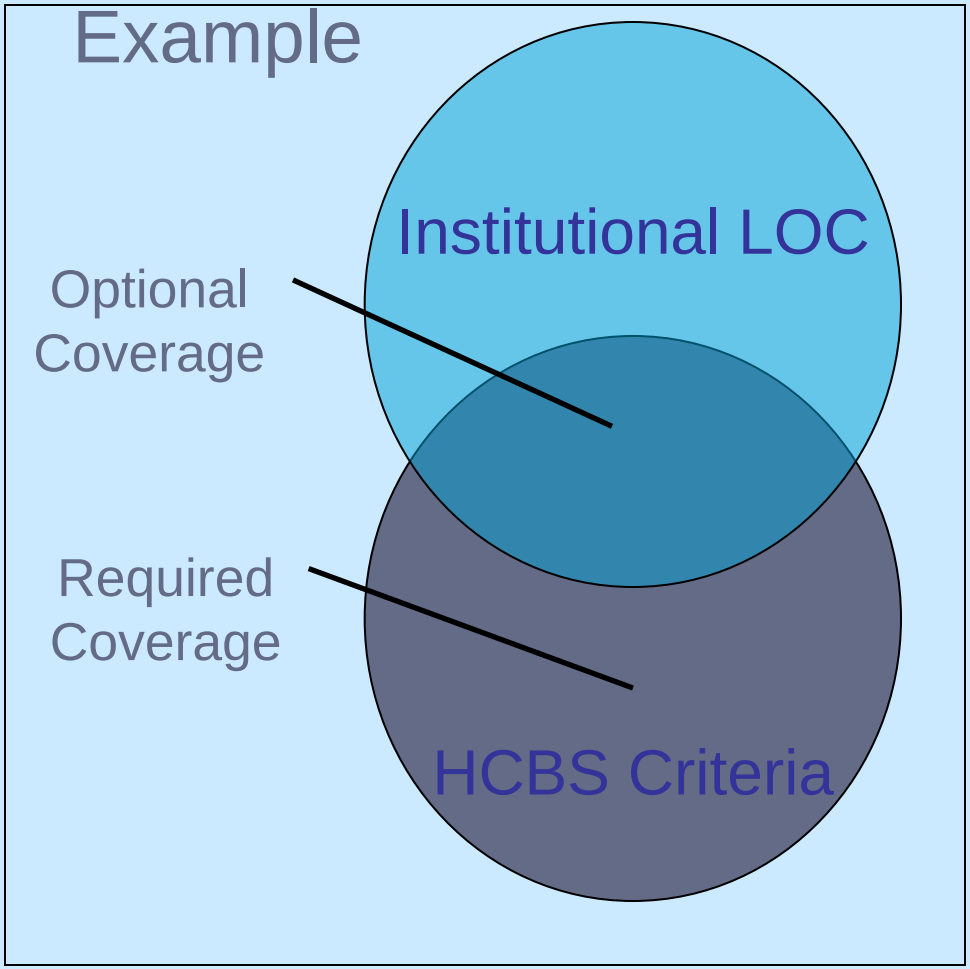
1915(i) Needs-Based Criteria

- 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

- 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

- 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)

- 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

- New Regulations for 1915(i) State plan HCBS were published on January 16, 2014
- Effective date: March 17, 2014
- 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

Medicaid HCBS Provided in a Managed Care Delivery System

- 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

- 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

- 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.

1915(j) Self-Directed Personal Assistance Services State Plan Option

- Provides a self-directed service delivery model for:
  - State plan personal care benefit and/or
  - Home and community-based services under section 1915(c) waiver
- State flexibility:
  - The State could limit the number of individuals who will self-direct their PAS
  - The State could limit the option to certain areas of the State or offer it statewide
  - The State could target the population using section 1915(c) waiver services

Section 1915(j) Features

- Individuals have “employer” authority - can hire, fire, supervise and manage workers capable of providing the assigned tasks

AND

- Individuals have “budget” authority - can purchase personal assistance and related services from their budget allocation

Section 1915(j) Features

- Participation is voluntary
  - Can disenroll at any time
- Participants set their own provider qualifications and train their providers of PAS
- Participants determine amount paid for a service, support or item
- Self -directed State plan PAS is not available to individuals who reside in a home or property that is owned, operated or controlled by a provider of services not related to the individual by blood or marriage.

Section 1915(j) Features

- If the State Medicaid agency allows the following, participants can:
  - Hire legally liable relatives (e.g., parents, spouses)
  - Manage a cash disbursement
  - Allow for Permissible Purchases:
    - Purchase goods, supports, services or supplies that increase their independence or substitute for human assistance (to the extent expenditures would otherwise be made for the human assistance)
  - Use a discretionary amount of their budgets to purchase items not otherwise delineated in the budget or reserved for permissible purchases
  - Use a representative to help them direct their PAS

Section 1915(j): Resources

SMD Letters and Preprint

Medicaid.gov ➡ Medicaid ➡ By Topic ➡ Optional Benefits

1915(k) Community First Choice (CFC): Key Features

- State option to provide "person-centered" home and community-based attendant services and supports
- Effective October 1, 2011
- States receive 6 percentage point increase in FMAP
- Provided on a Statewide basis

Who May Receive CFC services?

- Must be eligible for medical assistance under the State plan
- Must meet an institutional level of care
- Must be part of an eligibility group that is entitled to receive nursing facility services; if not, income may not exceed 150% of FPL

What Are CFC services?

- Attendant services and supports to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing.
- Back-up systems (such as electronic devices) or mechanisms to ensure continuity of services and supports.
- The State must offer a voluntary training to individuals on how to select, manage and dismiss attendants.

Services - State Options

- Allow for transition costs such as security deposits for an apartment or utilities, purchasing bedding, basic kitchen supplies, and other necessities required for transition from an institution.

- Allow for the provision of services that increase independence or substitute for human assistance **to the extent that expenditures would have been made for the human assistance.**

Excluded Services

- Room and board
- Special education and related services provided under IDEA and vocational rehab
- Assistive technology devices and assistive technology services (other than those defined in 441.520(a)(3))*
- Medical supplies and equipment *
- Home modifications*

* These services may be provided if they meet the requirements at 441.520(b)(2)

CFC Setting Requirements

- Section 1915(k)(1)(A)(ii) requires that services must be provided in a home or community setting, that does not include a nursing facility, institution for mental diseases, or an ICF/IID.

- CFC home and community based setting regulations are described in §441.530

Consumer -Directed Service Delivery Models

- Agency-provider model
- Self-directed model with a service budget
- Other service delivery model approved by the Secretary.

Agency Provider Model

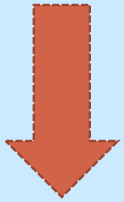
- Agency either provides or arranges for services
- Individual has a significant role in selection and dismissal of employees, for the delivery of their care, and the services and supports identified in the person-centered service plan.
- State establishes provider qualifications

Self-directed Model with Service Budget

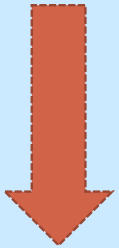
- Provides individuals with the maximum level of consumer control.
- Affords the person the authority to:
  - Recruit and hire or select attendant care providers
  - Dismiss providers
  - Supervise providers including assigning duties, managing schedules, training, evaluation, determining wages and authorizing payment
- Must include Financial Management Activities
  - Must make available for those who want it, and must provide this if individuals cannot manage the cash option without assistance
- At the state's discretion, may disburse cash or use vouchers.

Service Planning Process

Assessment of Functional Need



Person Centered Planning Process



Person-Centered Plan

State Requirements

- Maintenance of Existing Expenditures
  - For the first full 12 month period in which the state plan amendment is implemented, the State must maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided to elderly or disabled individuals under the state plan, waivers or demonstrations.

State Requirements

- Collaborate with a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives.
- Establish and maintain a comprehensive continuous quality assurance system specifically for this service.
- Collect and report information for Federal oversight and the completion of a Federal evaluation.

Data Collection

- Number of individuals who are estimated to receive CFC during fiscal year
- Number of individuals that received CFC during preceding year
- Number individuals served by type of disability, age, gender, education level, and employment status
- Individuals previously served under other HCBS program under State Plan or waiver

CMS Requirements

- CMS is required by 12/31/15 to conduct an evaluation in order to determine:
  - the effectiveness of this provision in allowing individuals to lead an independent life to the maximum extent possible,
  - the impact on physical and emotional health of individuals receiving these services
  - a comparative analysis of the costs of services provided under Community First Choice and those provided in an institution.
- An interim report of this evaluation has been completed and submitted to Congress.

Community First Choice: Resources

- Final Regulation published May 7, 2012

http://www.regulations.gov/#!documentDetail;D=CMS-2011-0019-0144

- Final HCBS Setting Criteria published January 16, 2014

https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

States with approved CFC programs

California

Oregon

Maryland

Montana

Contact Information

- For more information on 1915(c):
  - Regional Office Representative or
  - Kathy Poisal, 410-786-5940, Kathryn.Poisal@cms.hhs.gov or
  - Marge Sciulli 410-786-0691, Margherita.Sciulli@cms.hhs.gov
- For more information on 1915(i):
  - Regional Office Representative or
  - Kathy Poisal, 410-786-5940, Kathryn.Poisal@cms.hhs.gov
- For more information on 1915(j) and/or 1915(k):
  - Regional Office Representative
  - Kenya Cantwell, 410-786-1025, Kenya.Cantwell@cms.hhs.gov

Summary

Medicaid is complex, but the complexity offers various avenues/opportunities for increasing home and community-based services