



Medicaid Home and Community-Based Services

Jessica Loehr and Bernice Denbow

Division of Long-Term Services and Supports
Medicaid Benefits and Health Programs Group
Center for Medicaid and CHIP Services Centers
for Medicare & Medicaid Services

Kenya Cantwell

Division of Benefits and Coverage
Medicaid Benefits and Health Programs Group
Center for Medicaid and CHIP Services Centers
for Medicare & Medicaid Services

Purpose of Session

- Provide an overview of the authorities available through the Medicaid program that states may use to provide home and community-based services and supports, including self-directed services

Medicaid Authorities That Include HCBS

- Medicaid State Plan Services – 1905(a)
- Medicaid Home and Community Based Services Waivers (HCBS) – 1915(c)
- Medicaid State Plan HCBS – 1915(i)
- Medicaid Self-Directed Personal Assistance Services State Plan Option - 1915(j)
- Medicaid Community First Choice Option – 1915(k)
- Medicaid Managed Care Authorities
- Medicaid Section 1115 demonstration waivers

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 additional optional services
- States choose eligibility groups, optional services, payment levels, providers

Medicaid State Plan Requirements

- States must follow the rules in the Social Security 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
- Services must be medically necessary

Medicaid State Plan Requirements (cont'd.)

- EPSDT requirements for children up to (under) age 21
- Third party liability rules require Medicaid to be the “payer of last resort”
- Generally, services must be available statewide
- Beneficiaries have free choice of providers
- States establish provider qualifications
- States enroll all willing and qualified providers and establish payment for services
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

Medicaid Benefits in the Regular State Plan

- **MANDATORY**

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services
- Nursing Facility services
- Home Health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services
- Family Planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco Cessation counseling for pregnant women

- **OPTIONAL**

- Prescription Drugs
- Clinic services
- Therapies – PT/OT/Speech/Audiology
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services & Dentures
- Prosthetics
- Eyeglasses
- Other Licensed Practitioner services
- Private Duty Nursing services
- Personal Care Services
- Hospice
- Case Management & Targeted Case Management
- TB related services
- State Plan HCBS - 1915(i)
- Community First Choice Option - 1915(k)

State Plan HCBS

- Some HCBS are available through the State Plan:
 - 1905(a) Home Health (mandatory: skilled nursing, home health aide, medical supplies & equipment & appliances; optional: PT/OT/Speech/Audiology)
 - 1905(a) Personal Care (including consumer-directed)
 - 1905(a) Rehabilitative Services
 - 1915(i) State Plan HCBS
 - 1915(k) Community First Choice

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; and
 - Supports from families and communities.

1915(c) HCBS Waivers

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

Basic 1915(c) Waiver Facts

- There are approximately 250 1915(c) waivers in operation across the country, which serve more than a million individuals.
- 1915(c) waivers are the primary vehicle used by states to offer non-institutional services to individuals with significant disabilities.
- HCBS are designed as an alternative to institutional care, support community living & integration and can be a powerful tool in a state's effort to increase community services.

Section 1915(c) HCBS Waivers: Permissible Services

- 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

Self-Direction under 1915(c)

- 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(c) services
- May offer budget and/or employer authority
- States specify in the waiver 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.

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 Requirements

- **Home and Community-Based Settings Criteria:** To ensure full access to benefits of community living and the opportunity to receive services in the most integrated setting
- **Quality:** Every waiver must include a quality improvement strategy (more on next slide)

HCBS Waiver Quality

- States need to demonstrate compliance with waiver statutory assurances
- States must have an approved Quality Improvement Strategy: an evidence-based, continuous quality improvement process
- 1915(c) Federal Assurances
 - Level of Care
 - Service Plans
 - Qualified Providers
 - Health and Welfare
 - Administrative Authority
 - Financial Accountability

1915(c) HCBS Waiver 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 to their waiver.
- 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 Application and Instructions

- Waiver applications are web-based: *Version 3.6 HCBS Waiver Application*
- The application has a robust set of accompanying instructions: *Instructions, Technical Guide, and Review Criteria*
- Available at:
<https://wms-mmdl.cms.gov/WMS/faces/portal.jsp>

1915(i) State Plan HCBS

- Established by Deficit Reduction Act of 2005; became effective January 1, 2007 and modified under the Affordable Care Act effective October 1, 2010
- State option to amend the State Plan to offer HCBS
- Unique type of State Plan benefit with similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional level of care required under 1915(c) HCBS waivers; and no cost neutrality requirement

1915(i) State Plan HCBS

- Modified under the Affordable Care Act, 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 statewideness

1915(i) Services

- States have the option to cover any services permissible under 1915(c) waivers:
 - 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

Who May Receive State Plan HCBS?

- Eligible for medical assistance under the State Plan
- Reside in the community
- Have income that does not exceed 150% of FPL
- Meet state-defined needs-based criteria
- 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
- State option to target populations (disregard Medicaid comparability requirements) for a 5 year period with option to renew with CMS approval

1915(i) Needs-Based Criteria

- Determined by an individualized evaluation of need (e.g. individuals with the same condition may differ in ADL needs)
- May be functional criteria such as ADLs
- May include (but cannot only 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

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

1915(i) State Plan HCBS: Requirements

- Independent Evaluation to determine 1915(i) benefit eligibility
- Individual Assessment of need for services
- Individualized Person-Centered Service Plan
- Requirements to ensure against conflict of interest
- Projection (not limit) of number of individuals who will receive State Plan HCBS
- Payment methodology for each service
- Quality Improvement Strategy: States must ensure that HCBS meet Federal and State guidelines
- Home and Community-Based Settings Requirements
- Choice: Not waived under 1915(i) – Individuals must have choice of all willing and qualified providers

Self-Direction under 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

States with 1915(i) State Plan HCBS

- Arkansas (2)
- California
- Connecticut (2)
- Delaware
- District of Columbia (3)
- Idaho (3)
- Illinois
- Indiana (3)
- Iowa
- Maryland
- Michigan (2)
- Minnesota (2)
- Mississippi
- Nevada (2)
- New Hampshire (2)
- North Carolina
- North Dakota
- Ohio
- Oregon
- Texas

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 using a concurrent Medicaid managed care authority, such as a 1915(b) waiver.
- HCBS delivered with a managed care authority allow states to design and implement programs with a continuum of design features – from a limitation of providers to a fully capitated managed care arrangement that allows for risk sharing between the state and managed care entities.

Medicaid HCBS Provided in a Managed Care Delivery System

- In order to operate HCBS with a concurrent managed care authority, a state must complete and submit a separate application for each authority.
- Each application has different requirements, as each waiver authority is governed by distinct provisions of the Social Security Act and is subject to different Federal regulations.
- CMS reviews each application for its independent compliance with the various statutory and regulatory requirements.

HCBS Final Rule CMS 2249-F

- CMS published Final Regulations on January 16, 2014, that became effective on March 17, 2014 and included:
 - New regulations for 1915(i) State plan HCBS
 - New home and community-based settings requirements for 1915(c), 1915(i) and 1915(k) Medicaid authorities, to ensure full access to benefits of community living and the opportunity to receive services in the most integrated setting
 - Changes to current regulations for 1915(c) waivers, including option to combine multiple target groups in one waiver, person-centered planning, public notice, and additional compliance options for CMS

HCBS Settings Requirements

- Existing 1915(c) HCBS Waiver and 1915(i) and (k) State Plan options had until March 17, 2022 to transition their HCBS systems.
- New 1915(c), 1915(i), and 1915(k) settings must be compliant prior to approval.

HCBS Final Rule

- More information about the final regulation is available at:

<https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>

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:
 - Can limit the number of individuals who will self-direct
 - Can limit the option to certain areas of the state or offer it statewide
 - Can 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
- Individuals have “budget” authority - can purchase personal assistance and related services from their budget allocation
- Participation is voluntary - can disenroll at any time
- Participants set their own provider qualifications and train their providers of PAS

Section 1915(j) Features

- 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
- Service plan and budget process are completed using person centered and directed planning processes

Section 1915(j)

- 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, Preprint, and Guidance

www.medicaid.gov/medicaid/hcbs/authorities/1915-j/index.html

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

- State option to provide person-centered home and community-based attendant services and supports
- States receive 6 percentage point increase in FMAP
- Must be provided on a statewide basis and cannot be targeted to particular populations

Who is Eligible to 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

CFC Services - Required

- Attendant services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), 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's Option

- 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)

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.
- Collaborate with a Development and Implementation Council
 - Must include a majority of members with disabilities, elderly individuals, and their representatives.
- Establish and maintain a comprehensive continuous quality assurance system

Annual Data Collection

- Number of individuals who are estimated to receive CFC during fiscal year
- Number of individuals that received CFC during preceding year
- Number of 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

Community First Choice: Resources

- Medicaid.gov
 - <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html>
- Final Regulation, published May 7, 2012
- Final HCBS Setting Criteria, published January 16, 2014
- SMD letter #16-011, issued December 30, 2016
- CFC State Plan Template
- CFC Technical Guide

States with Approved CFC Programs

California

Oregon

Maryland

Montana

Texas

Washington

Connecticut

New York

Alaska

Minnesota

CMS 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 or
 - Kenya Cantwell- 410-786-1025; Kenya.Cantwell@cms.hhs.gov