

Home and Community Based
Services

1915(c), 1915(i), 1915(j)

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1915(c) Home and Community Based Services Waivers

- Operating a program of services under the authority of Section 1915(c) of the Social Security Act permits a State to waive certain Medicaid requirements in order to furnish an array of home and community based services that promote community living.
- States may waive the following provisions through 1915(c):
 - Comparability
 - Stewardness
 - Income and Resources for the Medically Needy

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1915(c) Home and Community Based Services Waivers

- **Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other Federal, state and local public programs as well as the supports that families and communities provide to individuals.**

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1915(c) Home and Community Based Services Waivers

- States have flexibility in designing waivers, including the latitude to (among others):
 - Determine the target group(s) of Medicaid beneficiaries served through the waiver;
 - Specify the services that are furnished to support participants in the community;
 - Incorporate opportunities for individuals to direct and manage their waiver services;
 - Determine qualifications of waiver providers;
 - Design strategies to assure the health and welfare of waiver participants;
 - Manage the waiver to provide the cost effective delivery of HCBS; and
 - Develop and implement a Quality Management Strategy to ensure that the waiver meets Federal statutory assurances.

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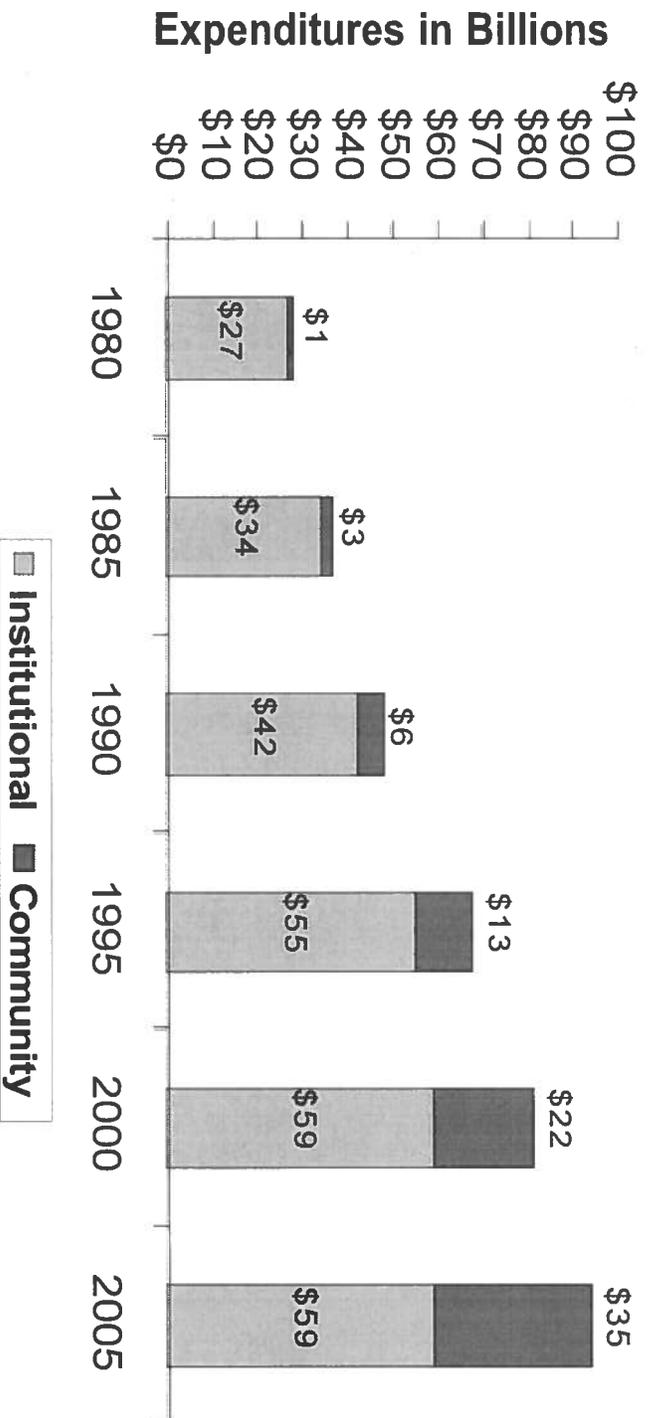
1915(c) Waiver Facts ...

- Approximately **300 HCBS waivers**
- Over **1,000,000 participants**
- 2006 HCBS Waiver Spending: more than **\$25 B**
- At least 7.5% of total Medicaid spending
- 24% of all Medicaid long-term services spending
- In, 2004, 67% of all Medicaid community services spending

The logo for the Centers for Medicare & Medicaid Services (CMS), featuring the letters 'CMS' in a bold, italicized, sans-serif font.

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Medicaid Institutional and Community-Based Expenditures in 2005 Dollars: FFY 1980-2005

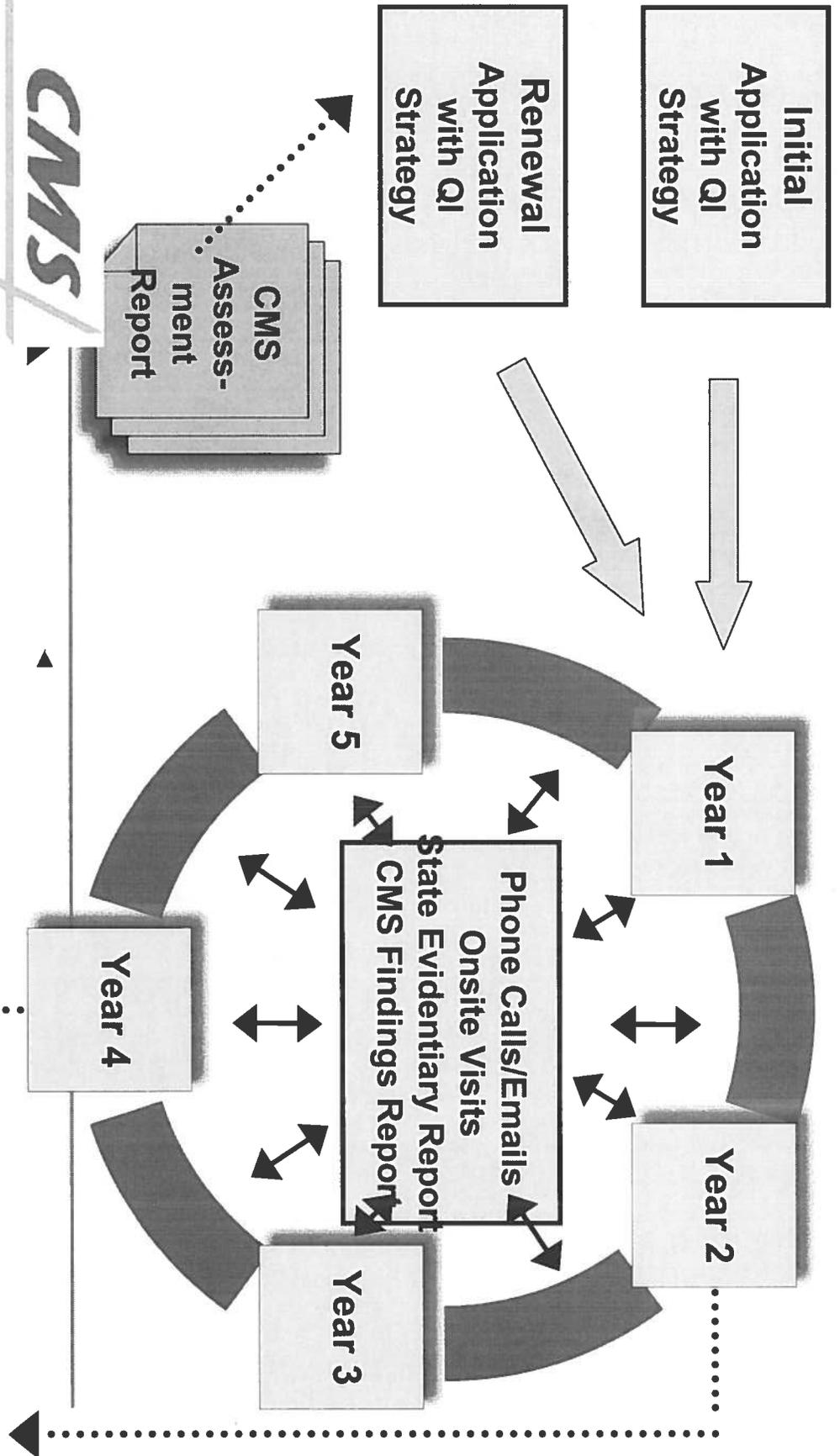


Source: CMS Form 64 Reports, adjusted for price increases based on the Skilled Nursing Facility Input Price Index. - Thomson Reuters LTC Chartbook

The HCBS Waiver Quality Life Cycle

State Submits to CMS

CMS ↔ State Ongoing Communication



Continuous Quality

Improvement:

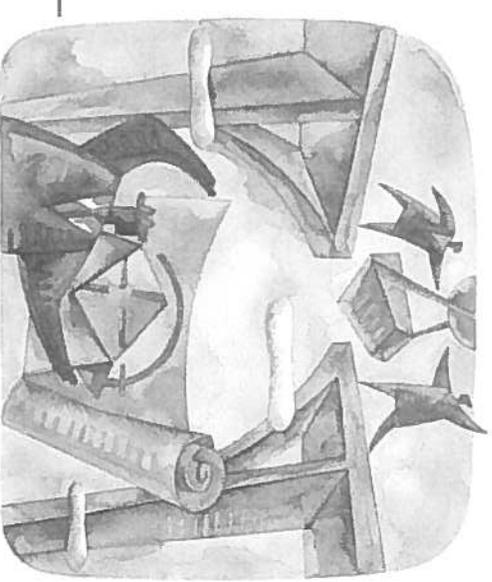
The HCBS Waiver Program



The HCBS waiver application (i.e., **QI strategy/ design**) and the **Quality Review Process** (i.e., **evidence-based review**) are the primary vehicles used to convey CMS expectations for the waiver program.

Quality Design in the HCBS Program: The Waiver Application

- State QI Design is embedded within the waiver application
 - **Discovery & remediation** activities accompany each respective assurance/appendix
 - Appendix H focuses on **system improvements**
 - QI strategy is extracted into one integrated document



Quality Review in the HCBS Program



- Implementation of QIS: State submits evidence that demonstrates oversight & compliance with the assurances
- Findings Report: CMS judges compliance based on discovery & remediation evidence and improvement activities
- CMS accepts the State's evidence and analysis of data as true (CMS oversight is not a look-behind)

1915(c) Waiver Approval Process

Initial Waivers

- States submit a waiver application, beginning a 90-day clock.
- CMS engages in a concurrent review process (Regional Office and Central Office)
- CMS negotiates with the State to ensure that the final document comports with Medicaid requirements.
- If there are outstanding issues, CMS may issue a formal Request for Additional Information (RAI).
- If the waiver meets all criteria (enumerated in Version 3.4 instructions), the waiver is approved initially for a 3-year period.

The logo for the Centers for Medicare & Medicaid Services (CMS). It features the letters "CMS" in a large, bold, sans-serif font. A horizontal line is positioned below the letters, and a diagonal line crosses the bottom right corner of the "S".

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1915(c) Waiver Approval Process

Renewal Waivers

- States submit a waiver application, beginning a 90-day clock.
- CMS engages in a concurrent review process (Regional Office and Central Office)
- CMS negotiates with the State to ensure that the final document comports with Medicaid requirements.
- If there are outstanding issues, CMS may issue a formal Request for Additional Information (RAI).
- If the waiver meets all criteria (enumerated in Version 3.4 instructions), the waiver is renewed for a 5-year period.

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1915(c) Home and Community Based Services Waivers -- Resources

- CMS recently revised the application used by States to apply for a 1915(c) HCBS waiver.
- The application is available in both Word® and Web-Based formats.
- The application has a robust set of accompanying instructions. Both documents are available at:
 - http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp

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Deficit Reduction Act

Major Provisions for HCBS

- 1915(i) HCBS State Plan Option
- 1915(j) Self-Directed PAS State Plan Option
- MFP
- PRTF

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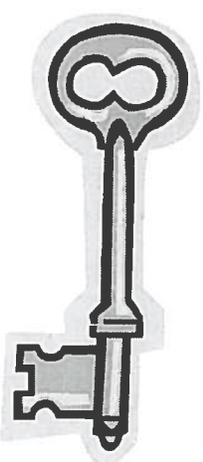
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**HCBS as a State Plan Option
1915(i) of the Social Security Act**

**Section 6086 of the
Deficit Reduction Act 2005**



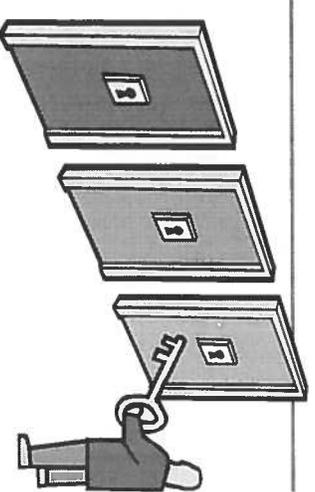
State Plan HCBS — Key



Features

- New section 1915(i) established by DRA of 2005. 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) Services

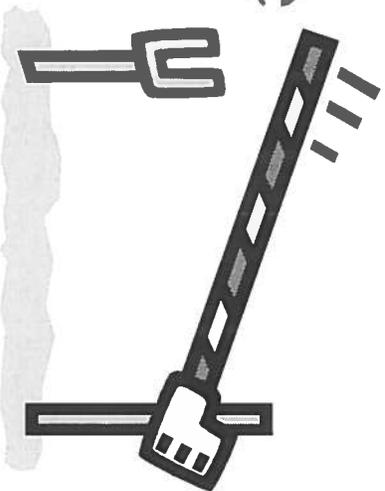


Any of the statutory 1915(c) services:

- 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

But NOT the 1915(c) “Other” flexibility to design unique HCBS waiver services

Who May Receive State plan HCBS?



- Must be eligible for medical assistance under the State plan
- Must have income that does not exceed 150% of FPL
- States must provide **needs-based criteria** to establish who can receive the benefit
- Must reside in the community

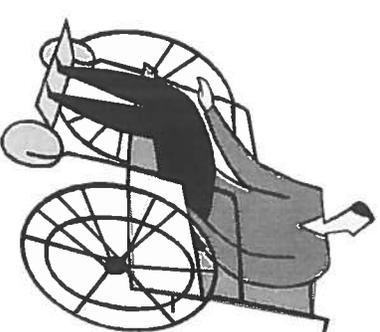
1915(i) Needs-Based Criteria

- 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 not:
 - descriptive characteristics of the person, or diagnosis
 - population characteristics
 - institutional levels of care



Needs-Based Criteria —

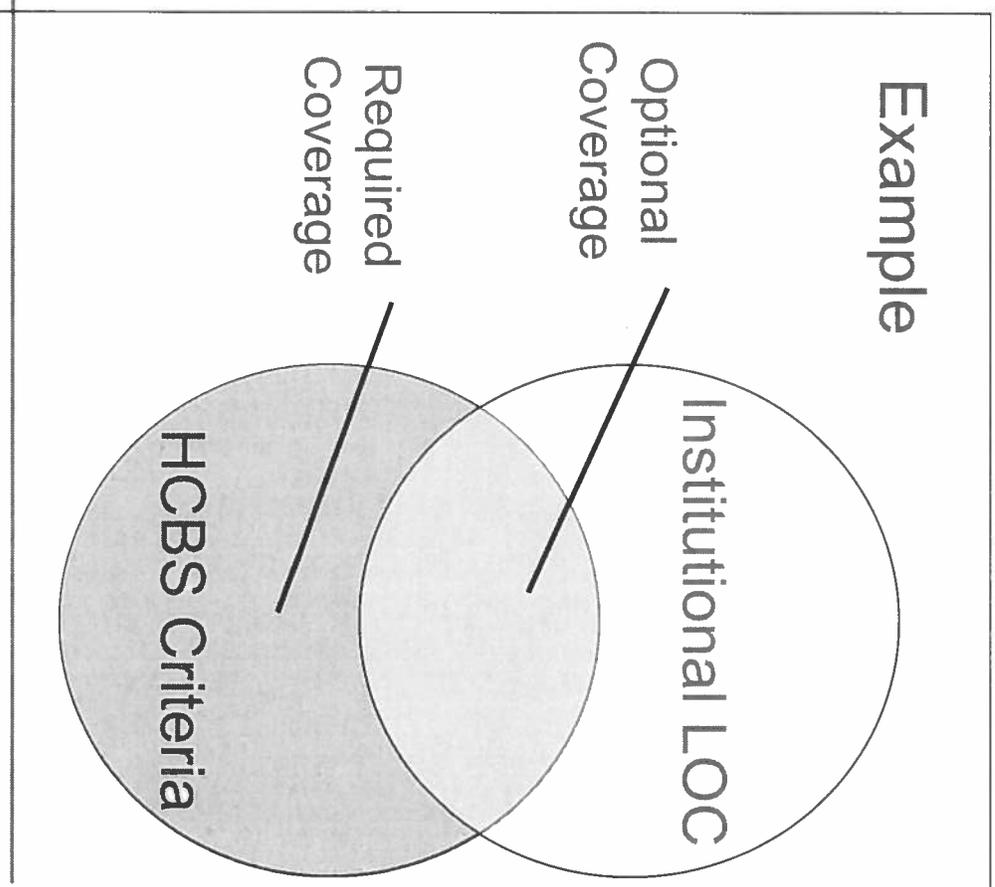
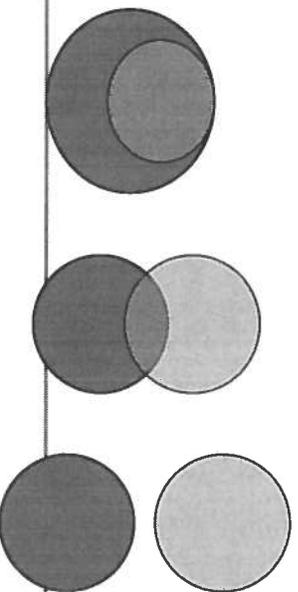
Who the benefit may cover



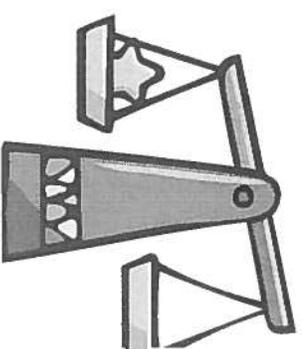
- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver LOC.
 - But there is no implied upper threshold of need. Therefore the universe of individuals served:
 - Must include some individuals with less need than institutional LOC
 - and May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

Needs-Based Criteria — Universe

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

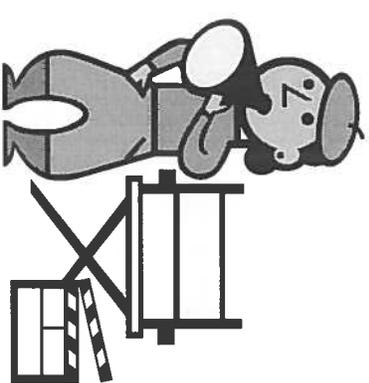


State Options



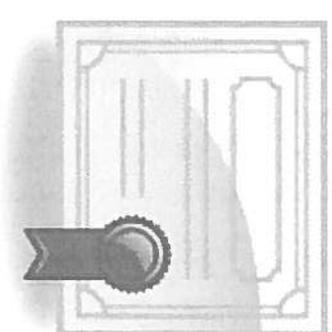
- Option to not apply income and resource rules for the medically needy
- States can limit number of participants who may receive benefit
- States can limit services to specified State areas (option to not apply statewideness)
- Self-Direction

Self-Direction in 1915(i)



- State Option
- Modeled on 1915(c) application
- May apply to some or all 1915(i) services
- May offer budget and/or employer authority
- Specific requirements for the service plan

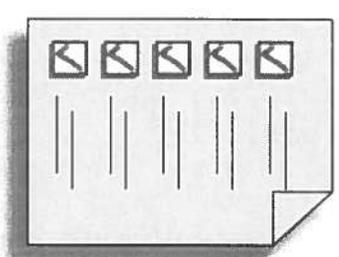
Quality Improvement in 1915(i)



- As a State plan service, no review & 3-5 year renewal needed as in waivers
- But unlike other State plan services, there is a QI requirement: States must ensure that HCBS meets Federal and State guidelines
- State quality improvement strategy

Under 1915(i)

States are to provide:



- ❑ Independent Evaluation to determine program eligibility
 - ❑ Individual Assessment of need for services
 - ❑ Individualized Plan of Care
 - ❑ Projection of number of individuals who will receive State plan HCBS
 - ❑ Payment methodology for each service
 - ❑ Quality Improvement
-

Similarities: HCBS Under

1915(i) State plan & 1915(c) Waivers

- ✓ Evaluation to determine program eligibility
- ✓ Assessment of need for services
- ✓ Plan of care
- ✓ Option to limit number of participants
- ✓ Quality Improvement requirements
- ✓ Self Direction option
- ✓ Ability to not apply state-wideness
- ✓ Option to not apply income and resource rules for the medically needy

Differences: HCBS Under

1915(i) State plan & 1915(c) Waivers

- Financial Eligibility Criteria
- Comparability/Targeting
- Program eligibility
- Institutional care requirements
- Length of time for operation
- Financial estimates
- Services

Financial Eligibility Criteria

1915(c)

- Eligibility group must be in State plan
- Option to use institutional deeming eligibility rules (special income level group)



1915(i)

- Must be eligible under State Plan
- 150% of FPL
- Uses community deeming rules
- Option for medically needy only to use institutional deeming rules

Waiver of Comparability (Targeting)

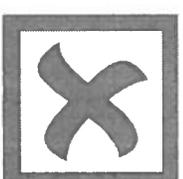
1915(c)

- May waive comparability



1915(i)

- May not waive comparability



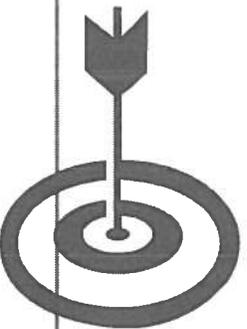
Program Eligibility

1915(c)

- Must target by institutional LOC
- May additionally target by population characteristics
- Disease or condition
- Age

1915(i)

- May not target by population characteristic
- Must establish needs-based eligibility criteria
- May have needs-based criteria for each HCBS



Needs-Based

Criteria

Level of Care

1915(c)



- Participants must meet institutional Level Of Care (“but for waiver services”)
- Waiver Level of Care must:

= **Institution LOC**

(Within LOC, may also be targeted at a subgroup)

1915(i)



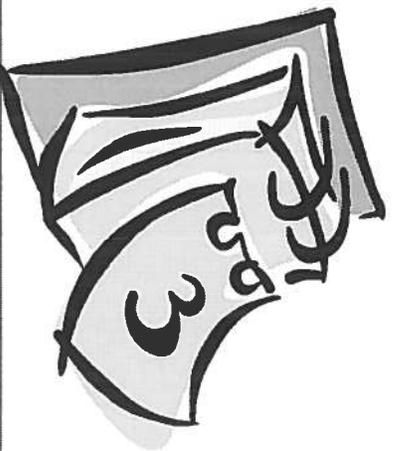
- Eligibility is needs based, not tied to institutional LOC
- But, institutional criteria must be more stringent
- Needs-based minimum eligibility criteria must be: “less stringent” than Institution LOC

Length of Time for Operation

1915(c)

1915(i)

- 3 years initial
- Indefinite
- 5 years upon renewal

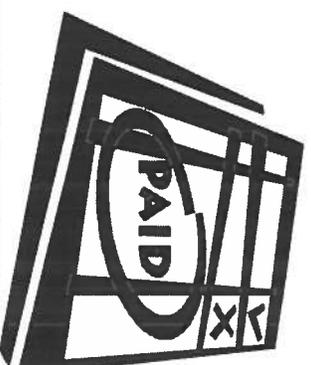


Financial Estimates

1915(c)

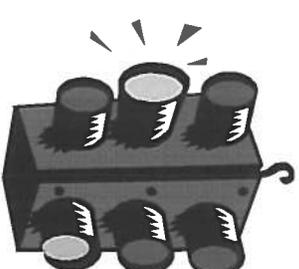
1915(i)

- Reasonable estimates of cost and utilization.
- Program must be cost neutral compared to institutional care
- Reveal payment methodology on Attachment 4.19-B of the State Plan.

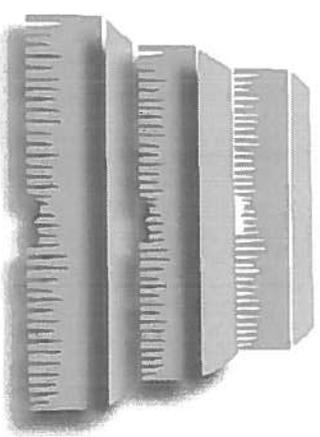


Experience 2007 - 2008

- More inquiries than submissions
 - Technical Assistance
- Iowa State plan HCBS
 - First to add State Plan HCBS benefit
 - Approved April 5, 2007
- Pending State plan amendments



Possible Challenges for States using 1915(i)



- Regulation not yet final
- Eligibility determined by needs-based criteria
- Only 1 HCBS Benefit available per State
 - Deciding how to best use the option; competing priorities
- Cross-agency collaboration



State plan HCBS:

Resources

- Regulation published as NPRM April 4, 2008 (comment period ended June 3, 2008). Complete proposed rule (CMS2249P) at http://www.cms.hhs.gov/MedicaidGenInfo/08_Medicaidregulations.asp
 - State Medicaid Directors Letter released April 4, 2008
 - Draft State plan HCBS application available through CMS regional offices
-

State plan HCBS: Contact Information

- CMS Regional Office Representative
 - CMS Central Office:
Kathy Poisal Kathryn.Poisal@cms.hhs.gov
-

**Self-Directed Personal Assistance Services
1915(j) of the Social Security Act**

**Section 6087 of the
Deficit Reduction Act 2005**



Section 1915(j) Key Features

- Section 6087 of the Deficit Reduction Act of 2005
- Amends §1915 of SSA – new 1915 (j)
- Effective 1/1/07
- States may elect to provide self-directed personal assistance services (PAS) in the State Plan so demonstrations and waivers would not be necessary



Key Features

- Can target populations, limit numbers and limit by geographic areas
 - Requires assurances:
 - Safeguards to protect health and welfare & ensure financial accountability
 - Individuals are evaluated by the State for their need for personal care
 - Participation is voluntary and individuals are informed of feasible alternatives to the PAS program
 - Support system is available prior to and throughout enrollment
 - Annual report
 - Triennial evaluation of impact on health & welfare
-

Key Features

- Individuals have both employer and budget authority:
 - can hire, fire, supervise and manage workers capable of providing the assigned tasks
 - can purchase personal assistance and related services
 - At State's election:
 - Can permit hiring of legally liable relatives
 - Can permit individuals to purchase items that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance
 - Services may not be provided to individuals residing in property owned, operated or controlled by a provider of services not related by blood or marriage
-

Key Features

- Individuals have an approved self-directed service plan and budget
 - Individuals exercise choice and control over budget, planning and purchase of PAS
 - Individuals' needs, strengths, preferences for PAS are assessed
 - The plan for services and supports is developed using person-centered planning process
-

Key Features

- The budget is developed based on the assessment and plan, and a methodology that uses valid, reliable cost data
 - Amount is expected cost of services if not self-directed
 - May not restrict access to other medically necessary care & services not included in budget

Key Features

- Quality assurance and risk management techniques are in place



- State may employ a financial management entity to make payments to providers, track costs, make reports; payment at the 50% admin rate

State Medicaid Director Letter and Preprint

- SMD Letter, with preprint, issued September 13, 2007
 - Provides guidance to States
 - Assurances
 - Prospective cash disbursements at State's option
 - Voluntary and Involuntary Disenrollment
 - Quality Assurance and Improvement Plan to be described
 - Risk Management System to be described
-

Current Status

- Final Regulation expected to be published in late September
 - Five States have approved 1915(j)
 - Alabama
 - Oregon
 - Arkansas
 - Florida
 - New Jersey
-

Further Information

- **Carrie Smith, Technical Director, Disabled & Elderly Health Programs Group, CMS Central Office, 410-786-4485.**