

May 2011

Strengthening the Aging Network Issue Brief

*Medicaid Health Information Technology &
Administrative Funding for Systems Supporting
People with Disabilities and Older Adults*

Medicaid IT and Administrative Financing Options

INTRODUCTION

Through their Medicaid Agencies, States may claim federal Medicaid funds for activities which further the "proper and efficient" administration of the Medicaid State Plan for the state. Expenditures related to providing approved services to Medicaid members/enrollees as well as Medicaid administrative functions are eligible for federal financial participation (FFP) at varied percentages depending on the activity and/or item.

Administrative functions can include:

- Outreach activities undertaken to identify and enroll Medicaid members/enrollees into coverage
- Education and engagement of members
- Providing access to appropriate services at the appropriate time from the appropriate provider at the appropriate setting for an appropriate reimbursement
- Providing quality and financial oversight and management.

States have the option to explore Medicaid funding to support activities that meet the requirements specified above. States do not have to link specific activities to Medicaid members in order to claim Medicaid federal administrative funds, but they must calculate the administrative costs which can reasonably be attributed to Medicaid. An approved cost allocation plan for administrative functions must be submitted and approved by the Centers for Medicare & Medicaid Services (CMS). States also have the authority under 42 CFR 433, subpart C to receive enhanced FFP for design, development, or installation (90%) and operation (75%) of their Medicaid Management Information System (MMIS). The MMIS is an integrated mechanized claims processing and information retrieval system of systems. States may operate the MMIS themselves or contract with a fiscal agent.

In November 2010, CMS published a Notice of Proposed Regulation making changes to the MMIS Systems. This proposed rule changes the definition of Mechanized Claims Processing and Information Retrieval Systems to include

systems used for eligibility determination, enrollment, and eligibility reporting activities and provide for enhanced FFP (90%) for the design, development and installation or enhancement of eligibility determination systems until December 31, 2015, with enhanced FFP for maintenance and operations available for such systems beyond that date in certain circumstances.

FEDERAL MEDICAID FUNDING MANDATES AND OPPORTUNITIES FOR HEALTH INFORMATION TECHNOLOGY (HIT)

Federal mandates and opportunities through Health Insurance Exchanges (Exchange), Medicaid Eligibility Systems and Health Information Exchanges (HIEs) provide options for states to fund the infrastructure needed to maintain and improve the way health care is delivered to individuals with disabilities or who are aged. Enhanced Medicaid federal funding is available for health information technology (HIT) through ARRA-HITECH, the Patient Protection and Affordable Care Act (ACA) and the Medicaid Information Technical Initiative (MITA) that can be utilized to support the evolving health care delivery and financing mechanisms being considered, including Medical Homes, Accountable Health Plans and integrated Medicare-Medicaid Managed Care options for seniors and disabled.

Because of established program and operational requirements and timelines, automation through HIT is a must; however, one of the most significant new funding requirements is that enhanced Medicaid federal funding will not be available for duplicative, non-standardized information systems. The Centers for Medicare & Medicaid Services (CMS) is requiring a single statewide approach with common systems and a high level of integration if the state intends to access Medicaid enhanced funding.

The federal government provides enhanced funding for HIT, up to 90% for the design, development and implementation (DDI) of MMIS and 100% for Exchanges within certain parameters. If states adhere to those parameters, states can improve the way health care is delivered, expand and simplify access for individuals with disabilities or who are aged, and assure accountability and transparency. In addition, if states develop and implement strategies that cross initiatives, duplication of costs and effort can be reduced, which is critical with limited state budgets.

MEDICAID FUNDING REQUIREMENTS AND OPPORTUNITIES

As a result of federal legislation (ARRA and ACA) and a Notice of Proposed Regulation (NPRM), Medicaid can fund an expansive array of HIT at a rate up to 90%. Medicaid is therefore an advantageous way to fund HIT needed to support the transformation of health care delivery and administration for individuals with disabilities and the aged.

Medicaid funding, with its potential 90% formula, can be used to design, develop, and implement HIT infrastructure, as long as the system is built for Medicaid and used by Medicaid providers to serve Medicaid enrollees. A system designed for Medicaid and used by Medicaid providers to serve Medicaid enrollees can simultaneously provide the structural support for activities needed by other programs, as long as appropriate cost allocations are made when the system(s) are used beyond Medicaid (authorized by CMS via the Medicaid Information Technology Architecture (MITA) framework).

Federal funding at 75% is also available for ongoing operations; however, states must ensure all statutory and regulatory requirements are met and systems are implemented in a manner that minimizes the potential for fraud, waste and abuse. CMS will monitor compliance through systems performance reviews, focused reviews, and audits of the processes documented in the SMHP, and other planning documents. CMS may use a variety of audit/review tools, including, but not limited to, financial audits, State Program Integrity Reviews, and payment data analysis.

Enhanced Medicaid federal funding is available through the options provided in Table 1.

Table 1: Enhanced Medicaid Federal Funding for Medicaid Mechanized Claims Processing and Information Retrieval Systems (MMIS)

Authority	Activities
MMIS MITA	<p>IT and human resources for Medicaid Management Information System, including management of the following business activities.</p> <ul style="list-style-type: none"> • Member (eligibility, enrollment, disenrollment, information and support) • Provider (eligibility-registration and validation, enrollment, disenrollment, information and support) • Contractor (health services contracting - PCCM, PCP, MCO, PBM, ACA, administrative contracting – fiscal agent, enrollment broker, etc, information and support) • Claims (processing, adjudication) • Operation (payment, capitation, service authorization and cost recoveries) • Program (benefit and program administration, budget, accounting, program quality management and information) • Care (population, establish and manage case, manage registry) • Program Integrity (identify case and manage) • Business Relationship (establish and manage, communication, termination) <p>Examples:</p> <ul style="list-style-type: none"> • Design, development, and testing of a standard continuity of care record (CCR) or continuity of care document (CCD) based upon Medicaid claims • Building a portal between the MMIS and a clinical data repository or an immunization registry.
MMIS HIT	<p>Design, development, implementation and operation of systems, people & processes at 90% federal and 10% state share that are necessary to encourage the adoption of certified EHR technology for the promotion of health care quality and the electronic exchange of health information, including planning, implementation and operations.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Provider needs assessments, provider outreach, staff training and procuring technical assistance for Medicaid providers related to the adoption and meaningful use of certified EHR technology • Well-defined, developmental, and time-limited projects for identification and development of tools to connect to HIEs, record locator services, secure messaging gateways, provider directories, development of privacy and governance policies and procedures, master patient indexes, interfaces for data, secure messaging, the

	<p>electronic reporting of structured laboratory data and enabling e-prescribing.</p> <p>Cost allocation must account for other available Federal funding sources, the division of resources and activities across relevant payers, and the relative benefit to the State Medicaid program, among other factors.</p>
<p>MMIS Eligibility and Enrollment</p>	<p>Design, development, installation or enhancement of a state eligibility determination/redetermination and/or enrollment system at 90% federal and 10% state for up to 2015 and 75% federal and 25% state for ongoing operation.</p> <p>Standards & conditions that States must commit to in order to receive enhanced FFP:</p> <ul style="list-style-type: none"> • Use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces • Separation of business rules from core programming • Availability of business rules in both human and machine readable formats. • Align to and advance increasingly in MITA maturity for business, architecture, and data. • Ensure alignment with, and incorporation of, industry standards. • Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among States. • Support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public. • Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. • Ensure seamless coordination and integration with the Exchange(whether run by the State or Federal government), and allow interoperability with health information exchanges, public health agencies, human services

Where the state is the provider, transactional and on-going expenses derived from participation in health information exchange would not be eligible for the 90% HITECH Medicaid administrative match.

CROSS INITIATIVE HIT INFRASTRUCTURE POTENTIALLY ELIGIBLE FOR MEDICAID FUNDING

There are many HIT infrastructures that are needed across programs, which can be designed, developed and implemented for Medicaid and used to support non-Medicaid funded programs with the appropriate cost allocation. Examples are provided in Table 2.

Table 2: Cross Initiative HIT Potentially Eligible for Medicaid Funding

Category	Activities
Operations Management	State interfaces of a Health Information Exchange, including laboratories, registries, public health databases, emergency preparedness, other HIEs which are needed for providers to comply with meaningful use requirements.
Data Management	Creation or enhancement of a Data Warehouse/Repository across programs (cost allocated), for evaluation and data analysis for federal and state reporting, as well as external and internal management that complies with HIPPA Privacy and Security requirements related to authorization to data, access to data types and functions, role permissions, ability to further designate third parties, and security to prevent breaches.
Identity Management	Development of a Master Patient Index (cost allocated) across programs, Provider Registry and Entity Registry.
Provider Management	Website for Provider Enrollment and Provider Help-Line/Dedicated E-mail Address/Call Center (hardware, software, staffing)
Program Management	Hosting some Conferences/Convening Stakeholder Meetings, Business Process Modeling, SMHP updates/reporting, I-APD updates and relevant Environmental Scans/Gap Analyses related to the exchange of health information to support the meaningful use of health information.
Program Integrity	Systems related to fraud and abuse prevention activities across programs with appropriate cost allocation.
Member Management	Single Web Entry across programs with appropriate cost allocation
Business Relationships	Developing Data Sharing & Business Associate Agreements (legal support, staff) across programs with appropriate cost allocation.

STATE MEDICAID PARTICIPATION REQUIREMENTS

States must follow federal Medicaid rules and regulations related to how the money is allocated, spent, and accounted. State Participation requirements are provided in Table 3.

Table 3: State Medicaid Participation Requirements

The Medicaid Agency is the responsible entity and must be “in control” of the use of Medicaid dollars.
State dollars to draw down the federal financial participation (FFP) match must be available and documented.
States must comply with documentation requirements for claims submissions, processing and payment in order to access the funds and avoid audit issues.
State must have addressed the initiative in their State Medicaid Health Information Technology Plan (SMHP) prior to the submission of appropriate Advanced Planning Documents (APDs). APDs including Planning (P) and Implementation (I) APDs. They can be for Health Information Technology to support ARRA-HITECH Meaningful Use Provisions (HIT-I-APDs), Medicaid Eligibility, and “regular” Medicaid Management Information Systems

(MMIS) new and updated changes using the MITA framework.
States and their enrolled providers must abide by applicable federal laws, including but not limited to HIPAA, FERPA and 42 CFR Part II for Substance Use Treatment.
States must adhere to strict timelines and received pre-approval of all funding activities from CMS prior to action.
States must adhere to federal reporting requirements. Administrative and Service costs must be claimed on States' Title XIX Expenditure Reports (CMS-64 and CMS-37).
States must have an approved Cost Allocation Plan and must track and bill Medicaid accordingly.

MEDICAID ADMINISTRATIVE FUNDING

The federal government has approved cost allocation plans from States for expenditures for Medicaid-related administrative activities qualifying for Federal matching funds. For administrative expenditures to qualify, the activities must be related to the proper and efficient operation of the State Medicaid program. Case management has always been recognized as a cost directly related to the proper and efficient operation of the State Plan¹. Administrative case management (ACM) includes Medicaid eligibility determinations and redeterminations, intake processing, Medicaid outreach, and pre-admission screening for long term care. Other types of administrative costs necessary for the proper and efficient administration of the State plan include prior authorization for Medicaid services, Medicaid Management Information System design, development, implementation and operation, Early and Periodic Screening, Diagnostic and Treatment administration, Third Party Liability activities, and utilization review.

Unlike the FMAP for medical services, which is different for each State, the administrative matching rates are the same for all States. Expenditures necessary for the administration of the program generally are reimbursed at 50%; however, certain administrative expenditures qualify for higher Federal matching rates. For example, certain activities requiring skilled medical professionals (SMP) qualify for 75% Federal matching. However, CMS has made it clear that both the activity must require a SMP and the individual providing the service must be a SMP in order for the 75% enhanced funding. For example, administrative activities in school by school employees do not require the skill of a SMP and medical activities in a school

are services, not administrative functions; therefore school administrative match is at 50%. Some expenditure relating to the development of new information technology systems may qualify for Federal matching rates of 75% or 90%.

Allocation of costs related to administration of the Medicaid State Plan is determined through a Cost Allocation Plan as established in the OMB Circular A-87ⁱⁱ. States must include in their Cost Allocation Plan (CAP) certification of eligible public expenditures for which administrative FFP is to be claimed and the methodology.

CERTIFIED PUBLIC EXPENDITURES

Federal regulations allow a state to use certified public expenditures by a “unit of government” to fulfill the non-federal matching requirements for administrative activities under the Medicaid program. A unit of government can include an operating agency, a county or local government agency and an Indian Tribe. Public funds may be appropriated directly to Medicaid agency or transferred from another public agency or certified by the contributing public agency as representing expenditures eligible for FFP.ⁱⁱⁱ

COST ALLOCATION PLAN

To the degree that a governmental operating agency directs some fraction of its efforts exclusively to Medicaid claimable administrative services, and can accurately identify that fraction, it may claim an appropriate portion of its operating costs to support that function. These operating costs must be included in a cost allocation plan, which is governed by OMB A-87 and its companion guide ASMB C-10, with particular requirements outlined in Attachment D of OMB A-87. The cost allocation plan must be approved by the federal government and supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the operating agency. A Medicaid cost allocation plan must mirror its organizational structure. Any change to the structure and functions performed will necessitate a cost allocation plan amendment.

Federal regulations (45 CFR (Part 95, Subparts E, F, and G)) establish the basic cost allocation plan requirements, including preparation, submission, and approval of the actual cost allocation plan and the requirements for the systems to support the

costs reported on the CMS-64. Prior to claiming administrative costs, States must ensure that their methodologies for distinguishing administrative activities eligible for FFP conform to the guidelines and are included in the State's Cost Allocation Plan submitted to an approved by the Director of the Division of Cost Allocation in accordance to Federal regulations at 45 CFR, Subpart E. In addition, State operating agencies' time coding systems, which must be approved by the federal government prior to implementation, used to determine Medicaid utilization must be designed to distinguish allowable administrative costs from non-allowable expenses. All expenditures allocated through the cost allocation system must be based on actual costs incurred and an audit trail provided for the expenditures claimed in the cost allocation process.

The cost of services provided by one agency to another within the governmental unit may include allowable direct costs of the service plus a pro rate share of indirect costs. A standard indirect cost allowance equal to ten percent of the direct salary and wage cost of providing the service (excluding overtime, shift premiums, and fringe benefits) may be used in lieu of determining the actual indirect costs of the service^{iv}. For non-governmental employees, a contract with the state Medicaid agency is required to perform certain administrative activities. If the employees work for the state or local government, the state must directly claim administrative costs.

States will also be required to submit changes to their Cost Allocation Plans (CAP) to accommodate health home planning activities authorized in Section 203 of the ACA. States can draw down the FMAP for planning activities before updating the CAP, as long as it is amended in a timely manner once the State obtains CMS approval for its health home planning activities. OMB Circular A-87^v, Attachment D, requires States to promptly submit amendments to the cost allocation plan to HHS for review and approval. For each allocated central service, the plan must also include the following: a brief description of the service, an identification of the unit rendering the service and the operating agencies receiving the service, the items of expense included in the cost of the service, the [method used to distribute the cost of the service to benefitted agencies](#), and a [summary schedule](#) showing the allocation of each service.

DEVELOPING AND COMPLY WITH A COST ALLOCATION PLAN: TIME STUDY AND DIRECT COSTS

Each state must develop, submit and gain approval for their Cost Allocation Plan. Included in the Cost Allocation Plan are various cost centers and within each cost center the specific activities performed, explanation of benefits and procedures used to identify measure and allocate costs to benefiting programs and activities.

General administrative and overhead cost allocations for state and local/county expenditures can be attributed on the basis of full time equivalent (FTE) employee counts within each function and distributed to the benefiting programs based on a statistically sound random time study methodology. General administrative and overhead costs incurred in support of the function can then be allocated to benefiting programs on an established basis. An example of an acceptable approach is the ratio of total salary charged to each program to the total salary charged to all programs combined

The Cost Allocation Plan must also address the Medicaid Administrative funding that is processed through the MMIS as a “claim”. Examples include HCBS Waiver Screenings, EPSDT outreach, Pre-admission Screening/Resident Review (PASRR), access services such as interpreters, mail order pharmacy benefit co-payments and transportation administrative fees.

Table 4: Checklist of Considerations for Cost Allocation & Cost Center Components for Benefiting Programs and Activities

Reporting	Excluded Funding Sources	Allocation of Staff Time	Sampling Methodology	Activities (By Code By Expenditure)
Periodicity: Quarterly	Other Federal funds	Direct Personnel: <ul style="list-style-type: none"> • Employed • Contracted 	Selection: <ul style="list-style-type: none"> • All • Sample 	Allowable

Reporting	Excluded Funding Sources	Allocation of Staff Time	Sampling Methodology	Activities (By Code By Expenditure)
Financial Data: <ul style="list-style-type: none"> Salaries Hours Worked Benefits Non-Salary Expenditures Supplies 	Non-federal used as Match for other Federal Funds	Skilled Professional Medical Person (SPM)	When: <ul style="list-style-type: none"> Random Moment Ongoing: All the Time Ongoing: Time Limited 	Travel Time
		Non-SPM	By Whom:	Non-Allowable
Indirect Costs: <ul style="list-style-type: none"> General Administration Central Staff Management Operations Telecommunications Financial Management 		Supervisory Time		General Administration
Executive Office Costs: <ul style="list-style-type: none"> legislative relations, external relations, communications office, tribal relations customer relations 		Support Personnel		
Occupancy Costs				
Finance & Management Operations Business Costs				
Program Costs by Program Cost Center, including Health Care				
Financial Review				
Accounting/Tracking IT Infrastructure and Audit				

Reporting	Excluded Funding Sources	Allocation of Staff Time	Sampling Methodology	Activities (By Code By Expenditure)
Trail				
Documentation				

STATE EXAMPLES

One example of a state using the use of Medicaid administrative funding^{vi} at a 50/50 rate to partially support all costs associated with the operation of the Aging and Disability Resource Centers (ADRCs) comes from Wisconsin. To determine the appropriate distribution of time dedicated to Medicaid administrative activities and then the appropriate federal financial participation (FFP), all staff at ADRCs performing Information and Assistance (I&A) or Long Term Care Functional Screen (LTCFS) activities report 100% of their time at 15 minute increments using an excel based workbook^{vii}. The coding configuration incorporates a parallel structure to account for both reimbursable and non-reimbursable Medicaid activities and only costs that have been incurred are eligible to be reimbursed^{viii}.

Kentucky draws down Medicaid School Based Administrative Claiming (SBAC)^{ix} for the time school districts employees spend in administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. SBAC involves all school district staff who, as part of their routine job duties, helps students and their families learn about Medicaid, apply for Medicaid benefits, and refer students to community medical and mental health providers or “collaborate with other school staff or community agencies to better address the health care needs of students”^x.

OTHER MEDICAID FUNDING FOR ADMINISTRATIVE TYPE FUNCTIONS

While administrative case management has always been recognized as a cost directly related to the proper and efficient operation of the State Plan^{xi}, states can also provide case management through Targeted Case Management (TCM) and

Home and Community Based Services Waiver (HCBS). While some case management activities may fall within the scope of both administrative and TCM, a State may not claim the same costs both as TCM and ACM at the same time. If the activities are provided as administrative services, the FFP is 50% or 75% if the services meet the requirement for skilled professional medical personnel (SPMP), which qualifies for 75% FFP.

TARGETED CASE MANAGEMENT(TCM)

TCM federal requirements provide states with the flexibility to restrict or target the geographic area (1902(a) (1)) and/or population (1902) (a) (10) (B)),^{xiii} allowing TCM programs specifically focused toward populations such as pregnant women, high risk mothers and/or newborns and children. It also allows a state to restrict coverage to certain geographic areas in order to phase in a service or limit the fiscal impact. While this can also be done through a 1915(b) waiver, this option to restrict or target is not provided for in most other Medicaid services. All other federal Medicaid requirements related to free choice of provider, coverage, medical necessity, claims and payment apply to TCM.

Table 5: Targeted & Administrative Case Management

Framework	Target Case Management	Administrative
Eligible Population	Eligible by Targeted Medicaid Population	Medicaid Population Appropriate for Activity
Providers	State Defined Qualified Provider, Cannot Restrict Free Choice of Provider	State Determined
Outreach		Access to Medicaid eligibility & enrollment to Medicaid member or potential Medicaid member

Framework	Target Case Management	Administrative
Assessment	Assessment Medical, Social, Educational and Other to Medicaid member; Client History; Needs Identification; Documentation; Gathering Information from other sources	Assessment of Long Term Care Needs Information, Referral and Intake to Medicaid member or potential Medicaid member
Care Plan	Development of Care Plan Goals Course of Action to Address Needs	Case Management directly related to the operation of State Plan
Services Based on Care Plan	Referral/Related Activities to Link to Medical, Social, Education and Other Programs/Services Referrals Scheduling Appointments Implementation Ensure Addressing Needs	State Plan Benefits and Long Term Care Options Counseling & Linkage Based on Treatment Plan
Oversight		Oversight
Location	Non-institutional except transition to Home or Non-residential	No Restriction
Frequency	As Needed	As Needed
Payment	Variable: State determined Methodology	Cost Allocation Administrative Funding Methodology

HOME AND COMMUNITY BASED SERVICES WAIVER (HCBS)^{xiii}

Case management is a core component of an HCBS waiver program, which provides a combination of both traditional medical services (either an extension of a current Medicaid State Plan option or a non-Medicaid State Plan Service) and non-medical services such as respite, environmental modifications and case management. Family members and friends may be providers of waiver services if they meet the specified provider qualifications. State Medicaid agencies must submit and have ultimate

responsibility for an HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity^{xiv}.

Provisions waived include state-wideness (Section 1902(a)(1)), comparability of services (Section 1902(a)(10)(B)), and income and resource rules applicable in the community (Section 1902(a)(10)(C)(i)(III))^{xv}.

Prepared by Patricia MacTaggart
The George Washington University
School of Public Health and Health Services
Department of Health Policy

ⁱ http://www.ssa.gov/OP_Home/ssact/title19/1902.htm#fn004, accessed 4/2/11

ⁱⁱ <http://www.whitehouse.gov/omb/circulars/a087/a087-all.html>, accessed 4/2/11

ⁱⁱⁱ <http://www.federalregister.gov/articles/2010/11/30/2010-30066/medicaid-program-cost-limit-for-providers-operated-by-units-of-government-and-provisions-to-ensure#p-21>, accessed 4/7/11

^{iv} http://www.whitehouse.gov/omb/circulars_a087_2004#cc, accessed 4/1/11

^v http://www.whitehouse.gov/omb/circulars_a087_2004#cc, accessed 4/1/11

^{vi} www.adrc-tae.org/tiki-download_file.php?fileId=29979, accessed 4/2/11

^{vii} www.adrc-tae.org/tiki-download_file.php?fileId=29979, accessed 4/2/11

^{viii} www.adrc-tae.org/tiki-download_file.php?fileId=29979, accessed 4/2/11

^{ix} <http://www.education.ky.gov/KDE/Administrative%2BResources/Finance%2Band%2BFunding/Medicaid%2BServices/Medicaid%2BSchool%2BBased%2BAdministrative%2BClaiming%2BProgram.htm>, accessed 4/2/11

^x <http://www.education.ky.gov/KDE/Administrative%2BResources/Finance%2Band%2BFunding/Medicaid%2BServices/Medicaid%2BSchool%2BBased%2BAdministrative%2BClaiming%2BProgram.htm>, accessed 4/2/11

^{xi} http://www.ssa.gov/OP_Home/ssact/title19/1902.htm#fn004, accessed 4/2/11

^{xii} http://www.cmwf.org/publications/publications_show.htm?doc_id=409144, accessed 4/2/11

^{xiii} [https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp), accessed 4/1/11

^{xiv} [https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp), accessed 4/1/11

^{xv} [https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](https://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp), accessed 4/1/11



National Association of States
United for Aging and Disabilities
1201 15th Street NW, Suite 350
Washington, DC 20005
Phone: 202-898-2578
www.nasuad.org