Medicaid 201: Home and Community Based Services

Kathy Poisal
Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Brandon Smith
Division of Benefits and Coverage
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
• Provide an overview of the authorities 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 – 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
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 “payor 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 self-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

- 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 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
There are approximately 285 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
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
• 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.
• 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.cms.gov/WMS/faces/portal.jsp
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
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
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

- Iowa
- Colorado
- Nevada
- Oregon
- Idaho (3)
- Connecticut
- California
- Indiana (3)

- Mississippi
- Maryland
- Delaware
- District of Columbia
- Texas
- Ohio
- New Hampshire
Medicaid 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.
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 have until March 17, 2022 to transition their HCBS systems.

• New 1915(c), 1915(i), and 1915(k) settings must be compliant prior to approval.
More information about the final regulation is available at:

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
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.
Assessment of Functional Need

Person Centered Planning Process

Person-Centered Plan
• 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
- 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
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