Home and Community Based Services

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Purpose of Session

- Provide an overview of the 1915(c) and 1915(i) 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

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 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

- 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 262 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

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 <u>not</u>:
  - descriptive characteristics of the person, or diagnosis
  - population characteristics
  - institutional levels of care

1915(i) Needs-Based Criteria

- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver 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
- Delaware
- District of Columbia
- Idaho (3)
- Indiana (3)
- Iowa
- Maryland
- Michigan
- Mississippi
- Nevada
- New Hampshire
- 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 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.

HCBS Final Rule

- More information about the final regulation is available at:

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

CMS Contact Information

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