

Medicaid and HCBS Basics

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Purpose of Session

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- Provide an overview of different approaches available through the Medicaid program that States may use to provide home and community-based supports and services
- Provide updates and information on home and community based services

Medicaid Authorities for HCBS

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- **Medicaid State Plan Services – Section 1905(a) of the Social Security Act (the Act)**
- **Medicaid Home and Community Based Services Waivers – Section 1915(c) of the Act**
- **Medicaid HCBS State Plan Option – 1915(i)**
- **Medicaid Self-directed Personal Assistance Services State Plan Option - 1915(j)**

Medicaid Authorities for HCBS (cont'd.)

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- **Medicaid Managed Care Authorities**
 - Section 1915(a)
 - Section 1915 (b)
 - Section 1115
- **Section 1115 demonstration programs**

Medicaid in Brief

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- 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 in Brief (cont'd.)

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- Medicaid mandates some services, States elect to provide other services (“optional services”)
- States choose eligibility groups, services, payment levels, providers

Medicaid State Plan Requirements

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- **States must follow the rules in the 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.**

Medicaid State Plan Requirements (cont'd.)

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- Services must be *medically necessary*
- Third party liability rules require Medicaid to be the “payer of last resort”
- Generally, services must be available Statewide
- Beneficiaries have freedom of choice of providers

Medicaid State Plan Requirements (cont'd.)

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- **State establishes provider qualifications**
- **State enrolls all willing and qualified providers**
- **Establishes payment for services (4.19-B pages)**
- **Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles**

Medicaid State Plan Services

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MANDATORY

- Physician services
- Laboratory & x-ray
- Inpatient hospital
- Outpatient hospital
- EPSDT
- Family planning
- Rural and federally-qualified health centers
- Nurse-midwife services
- NF services for adults
- Home health

OPTIONAL

- Dental services
- Therapies – PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- ICF/MR
- PRTF for <21
- Rehabilitative services
- HCBS
- Inpatient hospital services [other than those provided in an Institution for Mental Diseases (IMD)]
- Services for individuals 65+ in IMDs

HCBS under the State Plan

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Some HCBS are Available through the regular State plan:

- Personal Care
- Home Health (nursing, medical supplies & equipment, appliances for home use, optional PT/OT/Speech/Audiology)
- Rehabilitative Services
- Targeted Case Management
- Self-directed Personal Care

Medicaid Waivers

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- **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**

Medicaid HCBS Waivers -1915(c)

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- **Permits States to provide HCBS to people who would otherwise require Nursing Facility (NF), Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) or hospital Level of Care (LoC)**
- **Is the major tool for meeting rising demand for long-term services and supports**
- **Serves diverse target groups – including those with mental health support needs**
- **Services can be provided on a less than statewide basis**
- **Allows for participant-direction of services**

Basic 1915(c) Waiver Facts

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- There are more than 300 Waivers in operation across the country.
- These waivers serve approximately 1 million people annually and account for approximately \$26 billion in annual expenditures.
- 1915(c) waivers are the primary vehicle used by States to offer non-institutional services to individuals with significant disabilities.
- CMS published an Advanced Notice of Proposed Rulemaking to get public input on issues related to target groups, home and community based characteristics, and person-centered planning.

Section 1915(c) HCBS Waivers: Permissible Services

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- 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**

HCBS Waiver Quality

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- **States must demonstrate compliance with waiver statutory assurances**
- **States must have an approved Quality Improvement Strategy: an evidence-based, continuous quality improvement process**

Quality in HCBS Waivers

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1915(c) Federal Assurances

- Level of Care
- Service Plans
- Qualified Providers
- Health and Welfare
- Administrative Authority
- Financial Accountability

HCBS Waiver Requirements

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- **Costs:** HCBS must be “cost neutral” as compared to institutional services, on average for the individuals enrolled in the waiver
- **LOC:** Institutional levels of care define waiver level of care and the populations that may be targeted
- **Choice:** HCBS participants must have the choice of all willing and qualified providers

HCBS Waiver Requirements (cont'd.)

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- Package of HCBS is designed as an alternative to institutional care, supports community living & integration and can be a powerful tool in a State's effort to increase community services.
- **Processing:**
 - CMS approves a new waiver for a period of 3 years
 - States may request amendments at any time
 - 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

Medicaid HCBS Provided in a Managed Care Delivery System

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- HCBS services provided under 1915(c) are usually provided as “fee for service” – service is delivered, a claim is filed, and payment made
- HCBS services can also be provided as part of a managed care delivery system, which generally offers a capitated payment arrangement, using one of several Medicaid authorities:
 - 1915(a)
 - 1915(b)
 - 1115

Medicaid Managed Care Authorities

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- **Section 1915(a) – voluntary contract with a managed care organization that agrees to provide certain State plan services, including HCBS in a capitated arrangement**
- **Section 1915(b) – managed care delivery system for State plan services that may restrict providers, use selective contracting, use locality as central broker, use “savings” to provide additional services generated through savings**

Medicaid Managed Care Authorities for HCBS

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- **1915(a) is a contracting option**
- **1915(b) and 1115 are waiver and demonstration authorities (respectively) and States must submit an application to CMS for approval**

Section 1115 Demonstration Projects

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- **Section 1115 authority may be used when a State seeks to demonstrate whether a new service or intervention would lead to a change in Medicaid policy.**
- **The Secretary may waive compliance with any of the requirements of section 1902 of the Social Security Act.**
- **Services may be reimbursed as fee-for-service or under a managed care arrangement.**

Section 1115 Demonstration Projects (cont'd.)

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- **Processing:**
- **Application must describe the proposed innovation, the waivers requested, any costs not otherwise included as expenditures under section 1903, and how the project will be budget neutral.**
- **Typically, demonstration projects are approved for 5 years.**
- **Extensions and amendments are allowed.**

Other Flexibilities

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- States are successfully targeting individuals with chronic mental illness, children with life-threatening illness, children and adults with autism, and other special needs populations through various HCBS authorities, including 1915(c) HCBS waivers.

HCBS Waivers -- Assistance Contact Information

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- **Technical Director for HCBS Waivers**
- **Division of Community and Institutional Services,
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Summary

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- Medicaid is complex, but the complexity offers various avenues/opportunities for increasing home and community-based services
- Recent legislation added two additional avenues: 1915(i) and 1915(j)

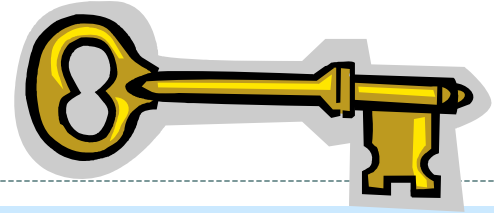
1915(i) State Plan Home and Community- Based Services (HCBS) Benefit

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State Plan HCBS — Key Features

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- 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

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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?

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- 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

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- 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



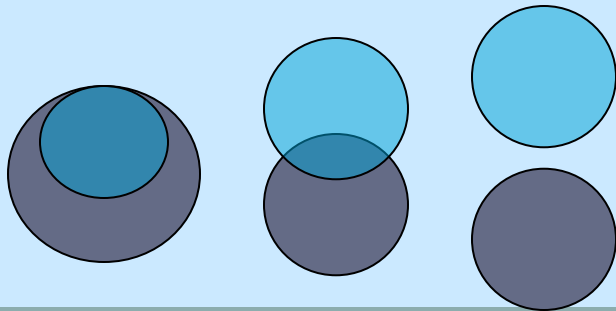
Needs-Based Criteria — Who the benefit may cover

- 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)

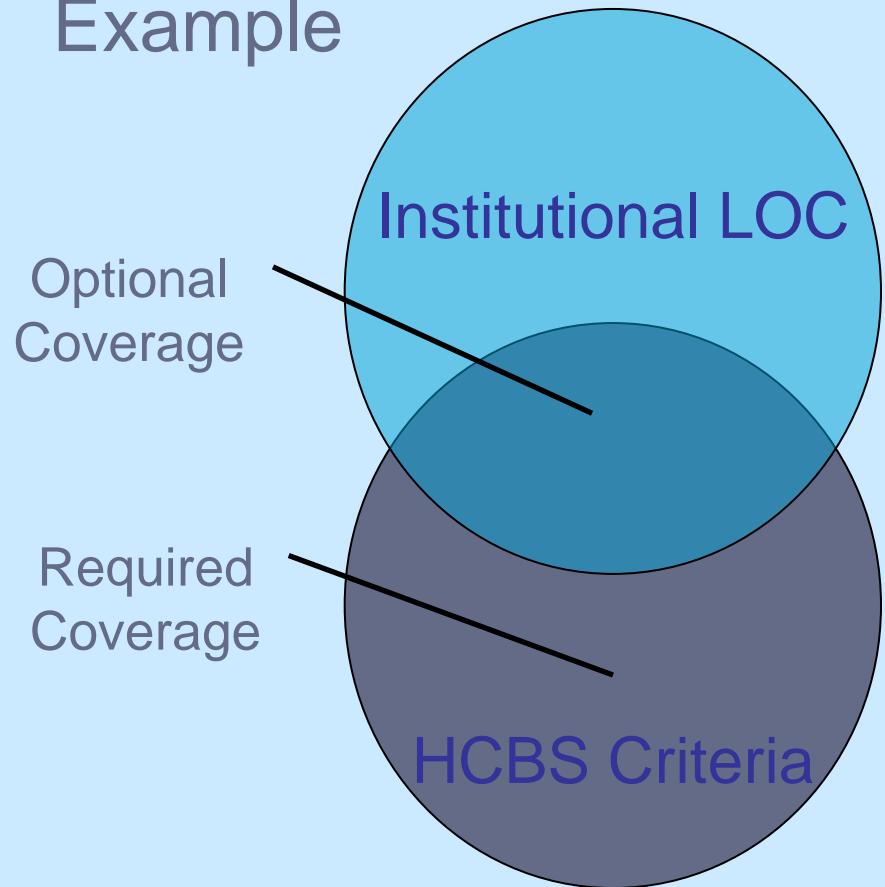
Needs-Based Criteria — Universe

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



Example



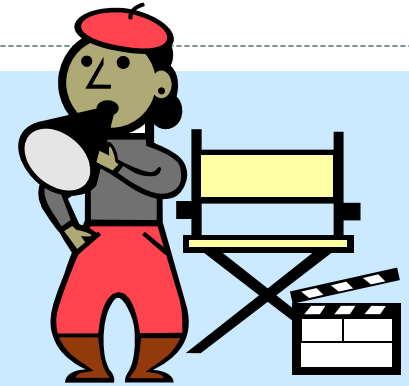
State Options

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- **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)

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- 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 Assurance -in 1915(i)

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

Under 1915(i) - States are to provide:

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- 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 Assurance

Similarities: HCBS under 1915(i) State plan & 1915(c) Waivers

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- Evaluation to determine program eligibility
- Assessment of need for services
- Plan of care
- Option to limit number of participants
- Quality Assurance requirements
- Self Direction option
- Ability to not apply state-wideness
- Option to not apply income and resource rules for the medically needy
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Differences: HCBS under 1915(i) State plan & 1915(c) Waivers

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

Mental Health Services

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- **1915(i) services for persons with chronic mental illness:**
 - Day Treatment or Partial Hospitalization
 - Psychosocial Rehabilitation
 - Clinic Services
- **No institutional level of care requirement; no cost neutrality requirement**

Experience 2007 - 2009

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- Iowa State plan HCBS
- Nevada State plan HCBS
- Colorado State Plan HCBS

Possible Challenges for States using 1915(i)

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- 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

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- 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_Medic_aidregulations.asp
- State Medicaid Directors Letter released April 4, 2008
- Draft State plan HCBS application available through CMS regional offices

State plan HCBS: Contact Information

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

Technical Assistance (TA)

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- CMS contracted with Acumen, LLC and their accomplished team of consultants to provide TA to States at all stages of program development and implementation.
- **TA will cover :**
 - Which authority will best meet States' needs
 - Understanding CMS requirements and designing programs accordingly
 - HCBS & HCBS State Plan Option [1915(i)]
 - Self-Directed PAS State Plan Option [1915(j)]
 - Self-Directed Services
 - Person-Centered Planning
 - Other areas as needed by States
- TA is available at no cost to State Medicaid Agencies.
- To request TA from Acumen, LLC, contact your CMS Regional Office, or Acumen at HCBS-support@acumenllc.com