

Medicaid Basics: What Every Program Administrator needs to Know

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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

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 (HCBS)– 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 “payor 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.

Other Flexibilities

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- States are successfully serving 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.

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 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

1915(i) Needs-Based Criteria

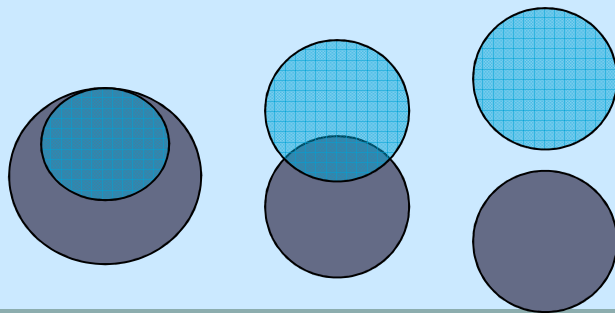
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- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
 - Must include some individuals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

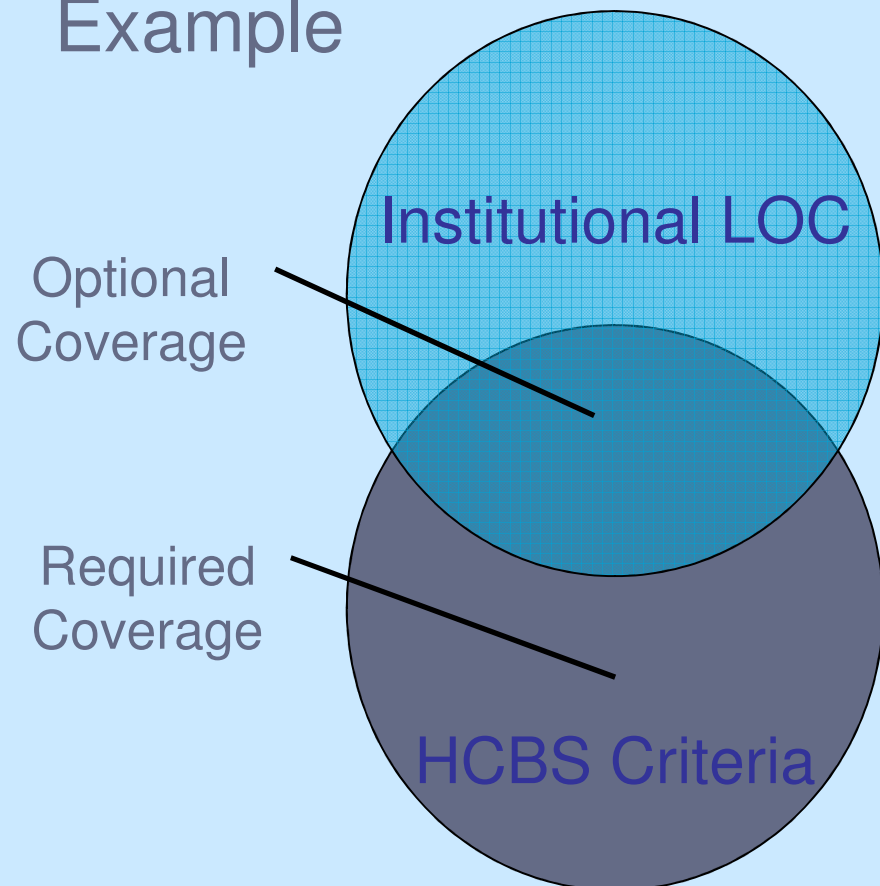
1915(i) Needs-Based Criteria

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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



1915(i) 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
-

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
- ≠

Financial Eligibility Criteria

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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)

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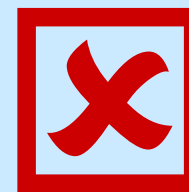
1915(c)

- **May waive comparability**



1915(i)

- **May not waive comparability**

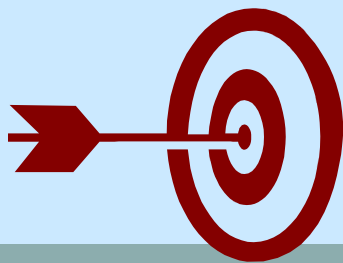


Program Eligibility

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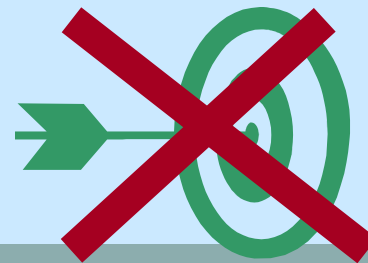
1915(c)

- 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



Level of Care

Needs-Based Criteria

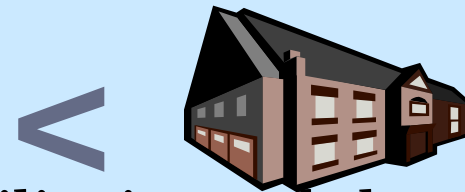
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1915(c)



- 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

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1915(c)

- 3 years initial
- 5 years upon renewal



1915(i)

- Indefinite

Financial Estimates

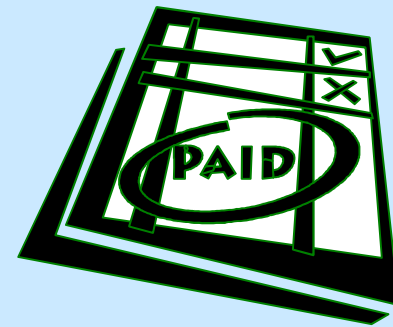
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1915(c)

- Reasonable estimates of cost and utilization.
- Program must be cost neutral compared to institutional care

1915(i)

- Reveal payment methodology on Attachment 4.19-B of the State Plan.



1915(i) 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

1915(i) Experience 2007 - 2009

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The following States have added the following HCBS to their Medicaid State Plan:

- Iowa: case management, habilitation
- Nevada: adult day health, habilitation, and for persons with chronic mental illness: day treatment/partial hospitalization
- Colorado: self-directed personal care, home health, and homemaker services

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/o8_Medic_aidregulations.asp
- State Medicaid Directors Letter released April 4, 2008
- Draft State plan HCBS application available through CMS regional offices

1915(j) Self-Directed Personal Assistance Services State Plan Option

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- Effective 1/1/07 (Enacted as section 6087 of the Deficit Reduction Act of 2005)
- Allows States the option to provide self-directed personal assistance services (PAS) in the Medicaid State plan

Section 1915(j)

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- What are self-directed PAS?
 - ✦ Personal care and related services under the Medicaid State plan, and/or
 - ✦ Home and community-based services under section 1915(c) waiver
 - ...that the State already has in place (Section 1915(j) offers the self-directed service delivery model, not new services)*
 - ✦ If selected by the State, PAS may also include “permissible purchases”

Section 1915(j) Features

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- Individuals have “employer” authority - can hire, fire, supervise and manage workers capable of providing the assigned tasks,

AND

- Individuals have “budget” authority - can purchase personal assistance and related services from their budget allocation

Section 1915(j) Features

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- Participation is voluntary
 - Can disenroll at any time
- Participants set their own provider qualifications and train their providers of PAS
- Participants determine amount paid for a service, support or item

Section 1915(j) Features

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- If a State elects the section 1915(j) option:
 - ✦ The State could target the population using section 1915(c) waiver services
 - ✦ The State could limit the number of individuals who will self-direct their PAS
 - ✦ The State could limit the option to certain areas of the State or offer it statewide

Section 1915(j) Features

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- If the State Medicaid agency allows the following, participants can:
 - Hire legally liable relatives (e.g., parents, spouses)
 - Manage a cash disbursement
 - 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) State Plan Amendments (SPAs)

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- The following States have received CMS approval for 1915(j) SPAs:
 - Alabama
 - Oregon
 - Arkansas
 - Florida
 - New Jersey
 - Texas
- Others pending:
 - California
 - Louisiana
 - Wisconsin

Resources

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- SMD Letter and Preprint:
 - <http://www.cms.hhs.gov/SMDL/SMD/>
[Search “Personal Assistance Services” or SMD #07-013]
- Final Rule on Section 1915(j) Self-Directed PAS State Plan Option Published in Federal Register on 10/3/08
 - http://federalregister.gov/OFRUpload/OFRData/2008-23102_PI.pdf
 - <http://frwebgate4.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=322294382120+13+1+0&WAIAction=retrieve>

Contact Information

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- **For further information on 1915(c):**
 - CMS Regional Office Representative
 - Mary Sowers, 410-786-6814 mary.sowers@cms.hhs.gov
- **For further information on 1915(i)**
 - CMS Regional Office Representative
 - Kathy Poisal, 410-786-5940 kathryn.poisal@cms.hhs.gov
- **For more information on 1915(j)**
 - Carrie Smith, 410-786-4485, Carrie.Smith@cms.hhs.gov
 - Marguerite Schervish, 410-786-7200, Marguerite.Schervish@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