Comparison of Medicaid 1915(c) Waiver, 1915(i), and 1915(k) State Plan Amendments

Adapted from: Comparative Analysis of Medicaid HCBS (1915 & 1115) Waivers and State Plan Amendments. Prepared by Cooper, Flanagan, Crisp. January 2014.

Features	§1915(c) Home and Community-Based Services Waiver	§1915(i) SPA State Plan Home and Community Based Services	§1915(k) SPA Community First Choice Option
Authority Type	Waiver - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html	State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html	State plan option - Information found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Community-First-Choice-1915-k.html
Effective Date	1981	Original: January 1, 2007 Revised: October 1, 2010 NPRM issued: May 3, 2012	Original: October 1, 2011 Final Rule: May 7, 2012
Purpose	Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution.	Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under 1915(c). May also provide services to individuals who meet the institutional level of care.	Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports. Provides a 6% FMAP increase for this option.
Requirements That May Be Waived	• Statewideness. • Comparability. • Community income rules for medically needy population.	• Comparability. • Community income rules for medically needy population.	Community income rules for medically needy population.
Application Process	Application submitted electronically via §1915(c) HCBS waiver application. Application and instructions found at: www.hcbswaivers.net	State plan amendment submitted on pre-print. Draft preprint can be obtained from CMS Regional Offices.	State plan amendment submitted on pre-print. Preprint can be obtained from CMS Regional Offices.

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Approval Duration	Initial application: 3 years. Renewal: 5 years.	One-time approval. Changes must be submitted to CMS and approved. If using targeting option, renewal every 5 years.	One-time approval. Changes must be submitted to CMS and approved.
Reporting	Annual reports.	Annual reports.	Annual reports on expenditures and utilization and quality measures.
Administration & Operation	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA). May be operated by another state agency under an interagency agreement or memorandum of understanding.	Administered by the Single State Medicaid Agency (SSMA).
Provider Agreements	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA. Delegation allowed to a provider agency under the Organized Health Care Delivery System or Provider of Financial Management Services. Requires written specification of delegated activity.	Required between providers and the SSMA.
Medicaid Eligibility	May use institutional income and resource rules for the medically needy (institutional deeming). May include the special income group of individuals with income up to 300% of SSI.	All individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. May include special income group of individuals with income up to 300% SSI. Individuals must be eligible for HCBS under a §1915(c), (d), or (e) waiver or§1115 demonstration program.	Individuals eligible for Medicaid under the State plan up to 150% of Federal Poverty Level. Individuals with income greater than 150% of the FPL may use the institutional deeming rules.

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Other Eligibility Criteria	Must meet institutional level of care.	For the 300% of SSI income group, must be eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program.	Individuals must meet institutional level of care. May include the special income group and receiving at least one §1915(c) HCBS waiver service per month.
Public Input	CMS encourages States to obtain public input into the development of the waiver. While States are not required to obtain public input other than through the state Medicaid Advisory Committee, soliciting the views of affected parties is a positive practice.	Proposed regulation is silent.	Must create a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives. State must consult and collaborate with the Council when developing and implementing a State Plan amendment to provide HCBS attendant services.
Target Groups	• Aged or disabled. • Intellectually disabled or developmentally disabled. • Mentally ill (ages 22-64). • Any subgroup of the above.	May define and limit the target group(s) served.	No targeting. Services must be provided on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

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Other Unique Requirements	None. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	Multiple State plan amendments covering different target groups permitted. **Cannot cover:** Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973.	MOE requirement for 1st fiscal year for services provided under §1115, §1905(a), and §1915, of the Act. Must establish & consult with a Development & Implementation Council with majority representation from consumers. **Cannot cover:** Certain assistive devices & assistive technology services; medical supplies & equipment, home modifications. Room & board costs except for allowable transition services. Special education and related services provided under IDEA that are education related only & vocational services provided under Rehab Act of 1973. **Increased FMAP** §1915(k)(2) of the Act provides that States offering this option to eligible individuals during a fiscal year quarter occurring on or after October 1, 2011 will be eligible for a 6 percentage point increase in the Federal medical assistance percentage (FMAP).

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Limits on Numbers Served	Allowed.	Not allowed.	Not allowed.
Waiting Lists	Allowed.	Not allowed.	Not allowed.
Combining Service Populations	Combining service populations is limited to: 1) Aged/Disabled. 2) Intellectually Disabled or Developmentally Disabled. 3) Mentally Ill. 4) Any subgroup of the above.	States may combine service populations.	States may combine service populations.
Caps on Individual Resource Allocations or Budgets	Allowed.	May determine process for setting individual budgets for participant-directed services.	May determine process for setting individual budgets for participant-directed services.
Allowable Services	Statutory Services: • Case management services. • Homemaker/home health aide services & personal care services. • Adult day health services. • Habilitation services. • Respite care. • "Other services requested by State as Secretary may approve." • Day treatment or other partial hospitalization services. • Psychosocial rehabilitation services. • Clinic services. • For individuals with	See §1915(c) services. Includes both §1915(c) statutory services and "other" category of services. Settings where individuals live must comport with community character guidance.	**MUST COVER:** • Assistance w/ ADLs, IADLs, & health related tasks. • Acquisition, maintenance & enhancement of skills necessary for individual to accomplish ADLs, IADLs, & health-related tasks. • Back-up systems or mechanisms to ensure continuity of services & supports. • Voluntary training on how to select, manage and dismiss staff. **MAY COVER** • Fiscal Management Services • Transition costs such as rent and utility

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Allowable Services (cont'd)	chronic mental illness. Settings where individuals live must comport with community character guidance.		deposits, 1st month's rental and utilities, bedding, basic, kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a NF, institution for mental diseases, or ICF-ID to a home & community-based setting where individual resides. • Expenditures relating to a need identified in an individual's person-centered plan that increases his/her independence or substitutes for human assistance to the extent the expenditures would otherwise be made for the human assistance. Settings where individuals live must comport with community character guidance.
Provider Qualifications	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.	Determined by state, subject to CMS approval.
Participant-directed Services	Allowed.	Allowed.	Required.
Hiring of Legally Responsible Individuals	Allowed at the State's discretion.	Allowed at the State's discretion.	Allowed at the State's discretion.
Cash Payments to Participants	Direct cash payments not permitted.	Direct cash payment not permitted.	Direct cash payments are permitted.

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Financial Management Services	Required if participant direction is offered. May be a waiver service, an administrative function, or performed directly by the SSMA.	Required if participant direction is offered. May be covered as a service, an administrative function, or performed directly by the SSMA.	Required depending on model of participant direction. May be covered as a service, an administrative function, or performed directly by the SSMA.
Employer Status for Participant Direction	Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model.	Participant may be the employer of record under a Fiscal/Employer Agent model or the entity may be the employer of record under an Agency with Choice model. Financial management supports are required to function as employer of record when the individual elects to exercise supervisory responsibility without employment responsibility.	Agency Provider Model: Services & supports provided by entities under contract or provider agreement. Participant has a significant role in the selection and dismissal of providers. Entity may provide services directly through their employees or arrange for the provision of services under the direction of the individual receiving services. Self-Directed Model with Service Budget: Service plan and budget directed by the individual and based on functional needs assessment. FMS must be available (SSMA may perform). Direct cash or vouchers may also be used. Other Service Delivery Model: States may propose other models
Goods and Services	Permitted as a waiver service.	Permitted as a service.	Permitted as a service.
Direct Payment of Providers	Required (state has options to meet this requirement).	Required.	Required.

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Provider Payments	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.	Payment item must be listed in the service plan (plan of care), provided by an enrolled provider, and provided prior to reimbursement.
Cost Requirements	Must be cost-effective. Average annual cost per person served under §1915(c) cannot exceed average annual cost of institutional care for each target group served.	None. Benefit limits may apply.	None. Benefit limits may apply. For the first full fiscal year in which the State Plan amendment is implemented, a State must maintain, or exceed, the level of expenditures for services provided under §1115, §1905(a), and §1915, of the Act, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.
Quality Management	Extensive quality management and quality improvement activities required per the HCBS Waiver Application, including how state will comply with all multiple waiver assurances and how state will conduct quality oversight, monitoring and discovery, remediation and improvement of issues relating to quality.	Pre-print requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement.	Requires a quality assurance and improvement plan including how state conducts discovery, remediation and quality improvement. State must provide system of performance measures, outcome measures, and satisfaction measures that will be monitored and evaluated.

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Interaction with State Plan Services, Waivers, & Amendments	Participants have access to and must utilize state plan services before using identical extended state plan services under the waiver. Waiver services may not duplicate state plan services. Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State plan services, §1915(c), §1915(i) and §1915(j) services simultaneously, so long as the service plan (plan of care) ensures duplication of services is not occurring. May be combined with other waivers such as §1915(a) or (b).	Individuals may be eligible for and receive State plan, §1915(c), §1915(i) and §1915(j) services simultaneously. May be combined with other waivers such as §1915(a) or (b).