

Medicaid Handbook: Interface with Behavioral Health Services

Module 9

Practical Guides to Medicaid State Plans and Waivers

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Module 9: Practical Guides to Medicaid State Plans and Waivers

What is the Medicaid State Plan?

A state's Medicaid State Plan is a contractual agreement, approved by the Centers for Medicare & Medicaid Services (CMS), that describes the nature and scope of the state's Medicaid program. The agreement is between the state and federal government and pledges the state's commitment to conform to the requirements of the Social Security Act and the official issuances of HHS. Each state develops its own State Plan, as required by §1902 of the Act. The State Plan dictates the policies and procedures that a state will follow in administering its Medicaid program, including those related to the methods of administration, eligibility criteria, covered services, and reimbursement methodologies.

Any time the federal government has a question relating to whether a state is appropriately drawing down federal funds, CMS will look at the State Plan to determine whether it reflects appropriate and accurate reimbursement policy. Therefore, it is in a state's best interest to ensure that its State Plan is complete and correct.

The processes and regulations that are described in this module are from the federal perspective only. States may have additional statutory or administrative processes related to State Plans, State Plan Amendments (SPAs), waivers, and waiver amendments. To understand how each state treats these issues, there must be an understanding of how the federal and state processes and regulations fit together.

Shortly after the federal government established the Medicaid program in 1965, it created and distributed to states a preprinted document outlining the program's major components, as specified in §1902 of the Act. The *preprint* creates the framework for a state's program; attachments to the preprint allow the state to describe its unique design, within the parameters of federal law. The document contains seven sections and a variety of attachments that, when taken together, should completely and accurately describe the state's Medicaid program. State Medicaid State Plans are generally arranged as follows (some states may add sections, but this is the general framework for the State Plan)—

STATE PLAN SUBMITTAL STATEMENT

Section 1. SINGLE STATE AGENCY ORGANIZATION

- 1.1 Designations and Authority
- 1.2 Organization for Administration
- 1.3 Statewide Operation
- 1.4 State Medical Care Advisory Committee
- 1.5 Pediatric Immunization Program

Section 2. COVERAGE AND ELIGIBILITY

- 2.1 Application, Determination of Eligibility, and Furnishing Medicaid
- 2.2 Coverage and Conditions of Eligibility
- 2.3 Residence

- 2.4 Blindness
 - 2.5 Disability
 - 2.6 Financial Eligibility
 - 2.7 Medicaid Furnished Out of State
- Section 3. SERVICES: GENERAL PROVISIONS
- 3.1 Amount, Duration, and Scope of Services
 - 3.2 Coordination of Medicaid with Medicare Part B
 - 3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases
 - 3.4 Special Requirements Applicable to Sterilization Procedures
 - 3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries
 - 3.6 Ambulatory Prenatal Care for Pregnant Women During Presumptive Eligibility Period
- Section 4. GENERAL PROGRAM ADMINISTRATION
- 4.1 Methods of Administration
 - 4.2 Hearings for Applicants and Recipients
 - 4.3 Safeguarding Information on Applicants and Recipients
 - 4.4 Medicaid Quality Control
 - 4.5 Medicaid Agency Fraud Detection and Investigation Program
 - 4.6 Reports
 - 4.7 Maintenance of Records
 - 4.8 Availability of Agency Program Manuals
 - 4.9 Reporting Provider Payments to the Internal Revenue Service
 - 4.10 Free Choice of Providers
 - 4.11 Relations With Standard-Setting and Survey Agencies
 - 4.12 Consultation to Medical Facilities
 - 4.13 Required Provider Agreement
 - 4.14 Utilization Control
 - 4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases
 - 4.16 Relations With State Health and Vocational Rehabilitation Agencies and Title V Grantees
 - 4.17 Liens and Recovering
 - 4.18 Cost Sharing and Similar Charges
 - 4.19 Payment for Services
 - 4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services
 - 4.21 Prohibition Against Reassignment of Provider Claims
 - 4.22 Third Party Liability
 - 4.23 Use of Contracts
 - 4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facilities
 - 4.25 Program for Licensing Administrators of Nursing Homes
 - 4.26 RESERVED
 - 4.27 Disclosure of Survey Information and Provider Contractor Evaluation
 - 4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities
 - 4.29 Conflict of Interest Provisions

- 4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals
 - 4.31 Disclosure of Information by Providers and Fiscal Agents
 - 4.32 Income and Eligibility Verification System
 - 4.33 Medicaid Eligibility Cards for Homeless Individuals
- Section 5. PERSONNEL ADMINISTRATION
- 5.1 Standards of Personnel Administration
 - 5.2 RESERVED
 - 5.3 Training Programs; Subprofessional and Volunteer Programs
- Section 6. FINANCIAL ADMINISTRATION
- 6.1 Fiscal Policies and Accountability
 - 6.2 Cost Allocation
 - 6.3 State Financial Participation
- Section 7. GENERAL PROVISIONS
- 7.1 Plan Amendments
 - 7.2 Nondiscrimination
 - 7.3 Maintenance of Aid to Families With Dependent Children (AFDC) Effort
 - 7.4 State Governor's Review

The information included in the preprint is standard language with citations to federal laws and/or regulations. The vast majority of detail about a state's Medicaid program is found in the attachments to the various sections. In the attachments, the state has an opportunity to include a narrative describing the particular aspect of the Medicaid program being addressed. For example, Section 4.19 describes payment for Medicaid services. The preprint language in Section 4.19(c) says, "Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility" and cites 42 CFR 447.40. The state has the option of checking one of two boxes, *yes* or *no*. If a state chooses the *yes* option, it is asked to provide a detailed description of its policy on this matter in an attachment. (Medicaid State Plan Preprint, February 25, 2013)

Because each state's Medicaid State Plan is the compilation of policies that describe its particular Medicaid program, and because the policies are so complicated and detailed, State Plans are generally voluminous. The hard copy of Ohio's State Plan, for example, is contained in eight, 4-inch binders. There is no requirement that states make their State Plans available online, although many have done or are doing so.

CMS has established a new Medicaid and Children's Health Insurance Program (CHIP) system (MACPro) to comply with the Paperwork Reduction Act requirements for public review and comments. MACPro will be a mechanism to ensure timely approval of Medicaid and CHIP SPAs and waivers. The MACPro system will serve as the system of record for all state Medicaid and CHIP actions. It is expected to become operational in 2013.¹ Having an understanding of the current process will be useful, as it will take years to migrate to the new system.

Examples of Medicaid State Plans

The following list provides links to Medicaid State Plans that are currently available on state websites. Module 10 provides instructions and resources regarding how and where to locate State Plans, waivers, and other important information.

Alaska

<http://www.hss.state.ak.us/commissioner/medicaidstateplan/default.htm>

Arizona

<http://azahcccs.gov/reporting/PoliciesPlans/stateplan.aspx>

California

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx>

Colorado

<http://www.colorado.gov/cs/Satellite?c=Page&cid=1197969486289&pagename=HCPF%2FHCPFLayout>

Florida

<http://ahca.myflorida.com/Medicaid/stateplan.shtml>

Indiana

http://www.indianamedicaid.com/ihcp/StatePlan/state_plan.asp

Iowa

<http://www.ime.state.ia.us/StatePlan/#search='medicaid%20state%20plan'>

Kansas

http://www.kdheks.gov/hcf/healthwave/state_plan.html

Kentucky

<http://chfs.ky.gov/dms/state.htm>

Louisiana

<http://bhsfweb.dhh.louisiana.gov/onlinemanualspublic/>

Michigan

http://www.michigan.gov/mdch/0,4612,7-132-2943_4860-225474--,00.html

Mississippi

<http://www.medicaid.ms.gov/MississippiStatePlan.aspx>

Nebraska

http://dhhs.ne.gov/medicaid/Pages/med_xixstateplan.aspx

Nevada

<https://dhcfnv.gov/MSPTableofContents.htm>

New York

http://www.health.ny.gov/regulations/state_plans/

North Carolina

<http://www.dhhs.state.nc.us/dma/plan/index.htm>

Oklahoma

<http://www.okhca.org/providers.aspx?id=122>

Oregon

http://www.oregon.gov/DHS/healthplan/tools_policy/stateplan.shtml

South Carolina

<https://www.scdhhs.gov/site-page/state-plan-under-title-xix-social-security-act-medical-assistance-program>

Tennessee

<http://www.tn.gov/tenncare/pol-stateplan.html>

Texas

<http://www.hhsc.state.tx.us/medicaid/StatePlan.html>

Utah

<http://www.health.utah.gov/medicaid/stplan/index.htm>

Vermont

<http://ovha.vermont.gov/administration/state-plan>

Virginia

<http://leg1.state.va.us/000/reg/TOC12030.HTM#C0010>

Washington

<http://hrsa.dshs.wa.gov/medicaidsp/>

West Virginia

<http://www.dhhr.wv.gov/bms/smp/Pages/WVMedicaidStatePlan.aspx>

Wisconsin

<http://dhs.wisconsin.gov/aboutdhs/DHCF/MASStatePlan/>

Wyoming

<http://www.health.wyo.gov/healthcarefin/medicaid/spa.html>

What is a State Plan Amendment?

A Medicaid *State Plan* is not the same thing as a *SPA*. A State Plan is the collection of policies upon which the State's Medicaid program is established. A SPA is an amendment to that collection of policies. Any time a state wishes to change its Medicaid program, it must request

and receive CMS approval. The vehicle by which these changes are made is the SPA process. Federal statutes and regulations require CMS to review and approve SPAs for consistency with the requirements of §1902(a) of the Social Security Act before a state may implement program changes.

Once a SPA is approved, it becomes part of the State Plan. For those states that make their State Plans and SPAs available online, the SPAs are posted separately from the State Plans and incorporated into the State Plan once approved by CMS, as described below.

Process for Amending the State Plan

The process by which a state changes its Medicaid program is as follows—

1. **The state identifies a needed or desired change.** This often happens as part of a state's operating budget approval process, during which the state's administrative or legislative body modifies the Medicaid program in an effort to produce cost savings. Other times, a state administrative agency or legislature may want a policy improvement or change that is unrelated to the budget. Frequently, this results in a state deciding to exercise a Medicaid policy option not currently in use or halting the use of the option, such as covering an optional eligibility group or providing (or not providing) an optional service. Another reason a state may seek a Medicaid policy change is in response to a federal law that requires compliance by the states. This has happened many times during the course of the Medicaid program's existence, most recently with passage of the Affordable Care Act in 2010. Many of the Affordable Care Act's provisions will require states to modify their State Plans to be in compliance with the federal law.

Other common reasons for amending the State Plan include—

- Adding or changing the amount, scope, or duration of a service
 - Adding or changing a requirement for a provider to participate in the state's Medicaid program
 - Adding a new type or class of provider
 - Changing eligibility determination processes
 - Adding or changing an eligibility group
 - Changing a reimbursement methodology
2. **If the state is submitting a SPA to amend a reimbursement methodology, it must provide notice of the proposed policy change to the public.** The purpose of the notice—which may appear in the state's newspapers and online register—is to inform Medicaid consumers, providers, stakeholders, and the general public of substantial proposed changes to the Medicaid State Plan. The notice also offers the opportunity to comment on such changes. The notice must describe the proposed change in reimbursement methods and standards, provide an estimate of any expected increase or decrease in annual expenditures, and explain why the state is making the change. Publication of the notice must occur prior to the proposed effective date of the change.

3. **The state drafts the SPA and submits it to CMS.** This process entails identifying the pages of the State Plan that must be amended, removing them from the State Plan, making the required changes, and submitting the amended pages to CMS. SPAs are generally transmitted to CMS as pages excerpted from the existing approved State Plan containing the provisions that the state wishes to modify. CMS is developing a new, electronic format for states to submit SPAs; until that occurs, states must submit their changes as attachments to e-mail communications or in hard copy form.

States must submit SPAs no later than the end of the quarter in which the state would like the SPA to be effective. For example, if the state wants its policy to become effective on July 1, it must submit its SPA by the end of September. Once approved, the requested effective date becomes the SPA effective date—in this example, July 1.

The State Plan pages that the state is seeking to amend must be accompanied by *CMS Form 179, Transmittal and Notice of Approval of State Plan Material*. This form captures basic but important information about the SPA, including the proposed effective date, the federal statute/regulation that is the authority for the program policy, the federal budgetary impact, and the State Plan page numbers to be impacted.

4. **CMS reviews the SPA.** CMS reviews the proposed specific amendment and all other provisions included on the submitted pages. For example, if a state is proposing to change its policy related to provision of dentures and the page on which this policy is contained also includes the policy related to provision of eyeglasses, CMS will review the policies related to both dentures and eyeglasses.

In addition, CMS also reviews any related or corresponding State Plan provisions contained elsewhere in the State Plan that are integral to understanding the pages being submitted for review and approval, including corresponding coverage and payment methodology pages. This review process may lead to the identification of existing State Plan provisions that the state is *not* proposing to modify and that are *not* integral to the proposed SPA modifications, but that appear to be contrary to federal statute, regulations, or established guidance. States have the option of resolving issues related to State Plan provisions that are *not* integral to the SPA through a separate process.

To improve national consistency in the issuance and application of Medicaid reimbursement policies, CMS developed the National Institutional Reimbursement Team (NIRT) and the National Non-Institutional Provider Team (NIPT). The NIRT is responsible for reviewing all institutional SPAs, providing technical assistance to the states, and developing Medicaid institutional reimbursement regulations and policy. NIPT functions similarly to the NIRT, but for noninstitutional providers.

Once the state submits the SPA to CMS, various groups within CMS review its different components. CMS has 90 days to take action (approve, deny, or issue a formal request for additional information [RAI]) on a SPA. During this time, CMS is *on the clock*. If CMS does not take action on the SPA by the end of this 90-day period, the SPA is deemed approved. CMS may send a denial of the SPA to the state

by the end of this first 90-day period, although that rarely happens. Most commonly, if CMS has significant questions about the SPA, CMS responds to the state within the 90-day period with an *RAI*. The *RAI* is an official action that *stops the clock*, meaning that CMS has met its regulatory requirement to take action within 90 days. This gives the state time to respond to CMS. CMS may also submit to the state an *informal RAI*, which is meant to gather information from the state without stopping the clock.

The RAI often includes a set of standard funding questions, which seek to gather additional information about a SPA's reimbursement component. Because these questions are standard, states generally submit responses with the SPA. These questions ask the state to describe how the state's share of each type of Medicaid payment is funded, whether the state uses intergovernmental transfers (IGTs) or certified public expenditures (CPEs), whether the state is using supplemental payments, and other reimbursement-related questions. CMS also will include questions related to coverage or reimbursement that may be specific to the particular SPA.

When the state responds to the RAI, the SPA is on a second 90-day clock. CMS has 90 days to approve or deny the SPA. As mentioned above, CMS can approve the SPA retroactive to the date for which the state requested approval.

5. **Once CMS has approved the SPA, the state implements the changes contained in the SPA.** Theoretically, the state is at risk if it implements the policy prior to CMS approval. Practically speaking, states frequently implement their changes before they are approved by CMS. If CMS were to deny a requested change or require significant edits to the SPA after the state already implemented the change, the state must repay the federal government the amount of federal reimbursement it collected while the unapproved changes were in effect.

Once CMS approves the SPA, the pages of the State Plan it approved become the new official State Plan pages. The state will remove the old pages and replace them with the newly approved pages.

Examples of State Plan Amendments

The following list provides links to SPAs that are available online. This list is not exhaustive. When a SPA is approved, it is incorporated into the State Plan. The SPA might remain on the state's website for historical or reference purposes even after the changes it proposes have been approved by CMS and incorporated into the State Plan.

Mississippi

<http://www.medicaid.ms.gov/MsStatePlanAmendments.aspx>

North Carolina

<http://www.ncdhhs.gov/dma/plan/index.htm>

Oregon

http://www.oregon.gov/OHA/healthplan/tools_policy/stateplan.shtml

South Carolina

<https://www.scdhhs.gov/site-page/state-plan-amendment-spa-approvals>

What is a Waiver?

A state's Medicaid State Plan contains extensive information about its Medicaid program. However, it is not the only document that describes eligibility, covered services, and reimbursement for services.

As described in Module 2, states have flexibility in designing and administering their Medicaid and CHIP plans, but several federal laws and regulations set minimum standards with which states must comply. Sections 1115 and 1915 of the Social Security Act define specific circumstances in which the federal government may, at a state's request, waive certain provisions of federal Medicaid and CHIP law. The principles of Medicaid law that are commonly waived under various waiver authorities are statewideness, freedom of choice of provider, and comparability of services.

Just as the State Plan is the state's contract with the federal government that describes how the Medicaid program is administered, a *waiver* is an agreement between the state and federal governments that exempts the state from certain provisions of federal law. The waiver—which must be approved by CMS—may include special terms and conditions (STCs) that define the strict circumstances under which and for whom the state is exempt from the provisions of federal Medicaid and CHIP laws.² Once a waiver is approved by CMS, it becomes an official document. It is kept separately from the State Plan or a SPA that outlines a portion of the state's Medicaid program.

Types of Waivers

Section 1915(b) Waiver

States use waiver authority under §1915(b) of the Social Security Act to create a mandatory managed care program. Section 1915(b) waiver managed care authority does the following—

- Allows the state to require enrollment of Medicare-Medicaid enrollees, foster care children, and other populations in managed care programs
- Allows the state to offer managed care statewide or limit the program by geography
- Allows a state to selectively contract with providers for managed care³

When using the §1915(b) waiver authority, the state can choose to do so under one or more subsections of §1915(b).

- **§1915(b)(1).** The state requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- **§1915(b)(2).** A locality will act as a central broker (i.e., agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs). This provides enrollees with more information about the range of health care options open to them.

- **§1915(b)(3).** Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees and to cover the cost of those added services through savings achieved under the waiver. In order to offer additional services under §1915(b)(3), the §1915(b)(3) authority must be used in conjunction with the §1915(b)(1) or §1915(b)(4) authority. If a state uses the §1915(b)(3) authority, the managed care program must be cost effective and must demonstrate that it will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services.
- **§1915(b)(4).** The state requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards. These standards are consistent with access, quality, and efficient and economic provision of covered care and services.⁴

According to CMS, as of April 2012, there are 48 approved §1915(b) waivers operating in 28 different states.

Section 1915(c) Waiver

Section 1915(c) waiver authority is used to offer long-term care home and community-based services (HCBS) that are not offered under a state’s Medicaid State Plan to individuals meeting a certain level of care and other eligibility criteria.

Section 1915(c) waiver authority—

- Allows the state to offer a different package of services (home and community-based services) to Medicaid long-term care consumers who meet the level of care and target group criteria specified in the waiver that the state offers in its Medicaid State Plan. This is a waiver of comparability of series.
- Allows the state to offer HCBS statewide or limited to certain geographical regions.⁵

Under a §1915(c) waiver, states can provide a combination of standard medical and nonmedical services. Standard services include, but are not limited to, case management (e.g., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community, such as home modifications. States can choose the degree to which they allow a consumer to direct provision of his or her services.

To be eligible for §1915(c) waiver services, an individual must require a hospital, nursing facility, or intermediate care facility for the developmentally disabled level of care—the cost of which would otherwise be reimbursed under the approved Medicaid State Plan.⁵ The state chooses the level or levels of care criteria and also additional target group eligibility requirements. The state can choose to offer HCBS under the waiver to aged or disabled consumers, aged *and* disabled consumers, consumers with a developmental disability, and/or consumers with a mental illness.

Section 1915(b)/(c) Waiver

Section 1915(b)/(c) waiver authority is used to implement a mandatory managed care program that includes home and community-based waiver services in a managed care arrangement. The §1915(b) authority is used to mandate enrollment in managed care and limit freedom of choice and/or selectively contract with providers; the §1915(c) authority is used to target eligibility to Medicaid consumers with a certain level of care and provide HCBS.

Section 1915(b)/(c) managed care authority does the following—

- Allows the state to selectively contract with providers
- Requires the state to apply for each waiver authority separately and concurrently
- Requires cost effectiveness for §1915(b) and cost neutrality for §1915(c)
- Allows the state to add non-State Plan HCBS in the capitation rate under the §1915(c) waiver authority or in the §1915(b) waiver as §1915(b)(3) services

Section 1115 Waiver

Section 1115 of the Social Security Act give states the flexibility to design and improve their Medicaid programs by letting them test new and innovative ways to deliver and pay for coverage. Under §1115, states have broad waiver authority—at the discretion of the Secretary of HHS—to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. For this reason, §1115 waivers are also referred to as research and demonstration waivers.

In Module 5, there is a discussion about using §1115 waivers to implement a managed care program; however, §1115 waivers offer states the ability to do more than institute managed care. One of the most common reasons states use the §1115 waiver is to offer Medicaid coverage to populations that the federal government generally does not permit. For example, some states choose to cover childless adults up to a certain percentage of the federal poverty guideline.

One unique requirement of the §1115 waiver is that it must be *budget neutral* to the federal government. This means that the state must show that over the duration of the entire waiver, federal Medicaid expenditures will not exceed the amount of money the federal government would have spent without the waiver.

Because §1115 waivers are vehicles for creative and flexible policy changes, CMS requires that many detailed parameters of the waiver should be memorialized in a list of STCs. Such STCs may include descriptions of the program, reporting, and financial requirements; the populations affected by the demonstration; the delivery system to be used; how the demonstration will be operated; and how the demonstration's budget neutrality will be monitored. STCs are unique to §1115 waivers and are not included in other types of waivers.

Examples of Waivers

1915(b) Waiver—Managed Care

Texas Star+Plus

<http://www.hhsc.state.tx.us/starplus/>

1915(c) Waiver—Home and Community-Based Services
Alabama Home and Community Based Services Living at Home Waiver for Persons With Intellectual Disabilities

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/AL0391.zip>

Kansas Serious Emotional Disturbance Waiver

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/KS0320R0300.zip>

1915(b)/(c) Waiver—Combined Managed Care and Home and Community-Based Services

North Carolina Innovations Waiver and Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan

<http://www.ncdhhs.gov/mhddsas/providers/1915bcWaiver/index.htm>

1115 Waiver—Demonstration

Colorado Adults Without Dependent Children Waiver

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-awdc-ca.pdf>

Vermont Global Commitment to Health

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>

What Are Waiver Applications and Waiver Amendments?

When a state first seeks to implement a waiver, it must submit a waiver application to CMS for approval. In the application, the state must describe the purpose of the waiver, the provisions of federal law it seeks to waive, eligibility parameters for participation in the waiver, the services it seeks to provide under the waiver, and provider requirements. A state wishing to amend, renew, or continue a waiver must seek CMS approval.^A

Process for Applying for or Amending a Waiver

The process for applying for or amending a waiver is the same as that of amending the State Plan, although the teams within CMS that review and approve waiver amendments are different from those that review and approve SPAs.

Examples of Waiver Applications and Amendments

The following list provides links to waiver applications and amendments that are available online. This list is not exhaustive.

^A A §1915(b) waiver generally does not extend beyond 2 years, unless a state requests a continuation; a §1915(c) waiver is initially approved for 3 years and renewed in 5-year increments; an §1115 waiver is approved for an initial 5-year period and renewed for an additional 3 years.

Waiver Application

New York Nursing Home Transition and Diversion Medicaid §1915(c) Waiver

http://www.health.ny.gov/facilities/long_term_care/waiver/docs/application_2005-12-12.pdf

Waiver Amendment

Indiana Traumatic Brain Injury §1915(c) Waiver

<https://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/IN40197R0200.zip>

Delaware Diamond State Health Plan §1115 Waiver

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf>

Self-Directed State Plan Services and Waiver Options

CMS developed the basic foundation of self-directed services in conjunction with the waiver authority to provide HCBS under §1915(c) of the Social Security Act. The national demonstration and evaluation of the Robert Wood Johnson *Cash and Counseling* project provided the programmatic and financial evidence that helped establish self-directed services in Medicaid policy and practice.

The Deficit Reduction Act (DRA) of 2005 authorized self-direction through two additional State Plan options—§1915(i) and §1915(j) of the Social Security Act. In 2010, the Affordable Care Act authorized another self-directed State Plan option, §1915(k) of the Social Security Act.

As referenced in Module 5, self-direction of Medicaid services is a model of service delivery that is provided as an alternative to managed care or the traditional fee-for-service (FFS) systems. Although each of the waiver and State Plan authorities has slightly different requirements and guidelines, there are consistent principles.

Common characteristics and requirements of self-directed options that have been identified by CMS include:

- A person-centered planning process is directed by the individual (with assistance as needed) to develop a person-centered plan. The individual's strengths, needs, and preferences are identified, including an evaluation of risk and identification of backup plans.
- An individualized budget based on the person-centered plan is “costed out” using a state-specified method for calculating the costs.
- Information and support are tailored to assist with self-direction.
- A “support broker” serves as a counselor or consultant. The support broker must be available to each individual to assist him or her in whatever way necessary to carry out the individual's plan. The support broker does not serve in a traditional case management role on behalf of the system or the provider, but acts as an agent of the individual and takes direction from the individual.
- Financial management services must be available to assist the individual with his or her budget. These services can include functions such as paying the individuals who provide supports, managing payroll or documentation associated with service

- provision, purchasing goods and services, and tracking the individual's overall budget.
- The state Medicaid agency is required to have a system of continuous quality assurance and improvement in place.⁶

¹ Medicaid and CHIP Program (MACPro) Portal. Retrieved July 9, 2013 from <http://www.medicaid.gov/State-Resource-Center/Medicaid-and-CHIP-Program-Portal/Medicaid-and-CHIP-Program-Portal.html>.

² Families USA. Citing Websites. *Frequently Asked Questions About Medicaid Waivers*. Retrieved July 9, 2013 from <http://www.familiesusa.org/issues/medicaid/other/waivers/waiver-faqs.html>.

³ Centers for Medicare and Medicaid Services. (December 2009.) *Providing Long Term Services and Supports in a Managed Care Delivery System. Enrollment Authorities and Rate Setting Techniques: Strategies States May Employ to Offer Managed HCBS, CMS Review Processes, and Quality Requirements*. [PDF version.] Retrieved July 9, 2013 from <http://www.hcbs.org/openFile.php/fid/9510/did/3262>.

⁴ Section 1915(b) Waiver Application. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

⁵ Section 1915(c) Waiver Application. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

⁶ Medicaid.gov. Self Directed Services. Retrieved July 9, 2013 from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>.

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